

(((Central Speech))) and Hearing Clinic inc.

an affiliate of Victoria General Hospital

2-1325 Markham Road

Winnipeg, Manitoba

R3T 4J6

Tel 204.275.7436

Fax 204.269.5083

PEDIATRIC REFERRAL FORM

Please fill in as completely as possible (fax or mail form to the fax number or address above)

Auditory-Verbal Therapy

Bone Anchored Implant

Cochlear Implant

Last Name: _____

First Name, Initial: _____

Date of Birth: _____

Parent(s): _____

Street Address: _____

Apt. #: _____

City: _____

Postal Code: _____

Phone: _____

Sex: _____ First Language: _____

MB Health 6-digit #: _____

9-digit #: _____

Audiometry - please attach a copy of most recent audiology report Date of Test (dd/mm/yyyy): _____

Audiologist: _____

Contact Info: _____

ENT: _____

Contact Info: _____

Diagnosis and Pertinent History: _____

Referral Source – if different from above

Name: _____

Address: _____

Specialty: _____

Phone: _____

Fax #: _____