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 #: ____