**Hearing Assessment Referral**

**Please Fax Completed Referrals to: (306) 766-5650**

**Child Name:** Click or tap here to enter text. **Gender:** Choose an item.

**Health Services Number (HSN):** Click or tap here to enter text. **Date:** Click or tap to enter a date.  
  
**Birth date:** Click or tap to enter a date. **Parent/Guardian Name:** Click or tap here to enter text.

**Phone:** Click or tap here to enter text. **Referring Clinician:** Click or tap here to enter text.

**Infant Hearing Screening:** Choose an item.

**This child has seen an otolaryngologist (ENT):** Choose an item. Name: Click or tap here to enter text.

**Reason for referral (please check all that apply):**

Family history of permanent childhood hearing loss

Pre-mature birth

Low birth-weight

Time spent in NICU

Speech-Language delay

Referred on school hearing screening

Educational concerns

Ear infection(s) \*(If recurring otitis media is the primary concern, please refer to an   
 otolaryngologist (ENT) prior to audiology referral).

**Other considerations:**

ADHD (query / confirmed)

Autism Spectrum Disorder (query / confirmed)

Syndrome or condition associated with hearing loss. Please specify:Click or tap here to enter text.

Developmental Delay

Non-responsive

Cleft Palate / Craniofacial

Behavioral Challenges

Other. Please describe: Click or tap here to enter text.

**Additional Concerns/Comments:** Click or tap here to enter text.