AurisCare Hearing
Unit 110,
875 Highland Road W
Kitchener – N2N 2Y2

Audiology Referral Form

Client Information:

Client Name: _____ D.O.B.: _____

Cellphone: _____ Home Phone: _____

e-mail address: _____

Reason for Referral:

Hearing tests

- ☐ Standard hearing assessment (19 years and over)
- ☐ Pediatric hearing assessment (5 years to 18 years)
- ☐ Pre-employment assessment
- ☐ Emergency Hearing Assessment (Sudden hearing loss)
  (Please call to request an emergency appointment)

Other

- ☐ Ear Wax removal
- ☐ Micro Suction
- ☐ Tinnitus assessment

Hearing and Hearing protection devices

- ☐ Hearing aid assessment/fitting/adjustment
- ☐ Custom ear plugs (Musician's/Noise/Swimmers)

Referring Physician / Health Professional Name: _____

E-mail: _____ Date: _____

Phone: _____ Fax: _____

Any additional notes about the client:

Please send us the completed form by:
E-mail: hear@auriscare.ca
Fax: 519-286-6015

If you have any questions please call us at:
+1 519 977 2299