Toronto Audiology Associates

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Appointment Date & Time: _____

PATIENT INFORMATION

Name: _____ DOB: _____ (day/month/year)

OHIP: _____ Version Code: _____

Address: _____

E-mail: _____

Telephone (Home): _____ (Work): _____

REFERRING PHYSICIAN

Physician: _____ Telephone: _____

Billing Number: _____ Fax: _____

Address: _____

_____

Physician's Signature: _____

Date: _____ (day/month/year)

SERVICE REQUESTED

- ☐ Hearing test
- ☐ Hearing Aid Evaluation
- ☐ Hearing Aid Recheck
- ☐ Central Auditory Processing

I hereby give my consent for the assessment of my child's hearing

_____ _____

Name of Parent or Legal Guardian (PRINT) Signature