Audiology and Speech Language Pathology Department

REFERRAL FORM

Phone: 604-875-2112

SPEECH AND LANGUAGE ASSESSMENT: *****IMPORTANT** FOR SPEECH/LANGUAGE REFERRALS*** -

***IN ORDER TO FACILITATE THE INTAKE PROCESS, IF CHILD IS OF SCHOOL AGE, PLEASE SPECIFY SCHOOL ATTENDED*: ____**

AUDIOLOGY (HEARING) ASSESSMENT

INPATIENT WARD: ____________

A.B.R. (AUDIOLOGICAL-THRESHOLD TEST)

APPROXIMATE DISCHARGE DATE: _______________

O.A.E. (AUDIOLOGICAL TEST)

OUTPATIENT

I. CHILD'S NAME: ____ D.O.B: ________________________ SEX: _________

E.D.C. ________________________ *(if premature)*

BCCH UNIT NUMBER: ____ P.H.N. ____

PARENT'S NAMES: ____ TELEPHONE: _________________________________

ADDRESS: ____ CITY: ____________________ POSTAL CODE _____________

REFERRING PHYSICIAN ____________________________ BILLING NO. ________________ TELEPHONE __________________

(Physician name & telephone number are required – referral will not be processed without this information)

II. REASON FOR REFERRAL:

III. PROVISIONAL DIAGNOSIS AND PERTINENT HISTORY:

IV. PREVIOUS ASSESSMENT AND / OR TREATMENT (if any):

NOTE: Either fax referral form to (604) 875-2743 or mail to B.C. Children's Hospital, Audiology and Speech Language Pathology Department, Room K2-192, 4480 Oak Street, Vancouver, BC V6H 3V4.

INTERNAL REFERRALS – FAX 2743 OR TUBE TO 342

(Form CH748 revised Oct 2010)