WEST COAST HEARING
EXPERT CARE ✦ CLEAR CONNECTIONS

☐ **Non-Urgent** ☐ **Urgent** (complete reverse side)

Name of Patient:_____

DOB:____/____/_____ **Phone:**_____
MM DD YYYY

REASON FOR REFERRAL

- ☐ Hearing loss / change in hearing
- ☐ Hearing aid assessment
- ☐ Tinnitus
- ☐ Test required prior to ENT consultation
- ☐ Balance concerns
- ☐ Aural fullness or discomfort
- ☐ Ear wax removal
- ☐ Employment/licensure hearing test
- ☐ Other, please specify:_____

REFERRING PHYSICIAN INFORMATION

Physician Name:_____

Phone #:_____ Fax #:_____

ADDITIONAL INFO:

190A - 29 Helmcken Rd. Victoria, BC V8Z 5G5
(250) 590-1122 | www.westcoasthearing.ca

WEST COAST HEARING
EXPERT CARE ✦ CLEAR CONNECTIONS

Please contact clinic directly by phone (250-590-1122) to schedule an urgent appointment.

Name of Patient:_____

DOB:____/____/_____Phone:_____
MM DD YYYY

REASON FOR URGENT REFERRAL

☐ Sudden hearing loss ☐ Ototoxicity monitoring

RELEVANT MEDICAL HISTORY

☐ History of ear infections ☐ Recent trauma / head injury

☐ Existing hearing loss ☐ Family history of hearing loss

☐ Current medications (e.g., antibiotics, chemotherapy)

☐ Other relevant conditions: _____

REFERRING PHYSICIAN INFORMATION

Physician Name:_____

Phone #:_____Fax #:_____

ADDITIONAL NOTES / COMMENTS:

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