NOVA SCOTIA HEARING & SPEECH CENTRES

REFERRAL

1-888-780-3330 (call for information)
www.nshsc.nshealth.ca

Hospital card imprint

Name: Last _____
First _____ Middle _____
Date of Birth: _____/_____/_____ (d / m / y) Sex: M ❑ F ❑
Address: _____
Apt. #: _____ City: _____
Province: _____ Postal Code: _____
Tel: (H) _____ (W) _____

Health #: _____
Province: NS ❑ or _____ Expiry Date: ____/____/____
Next of Kin: _____ Tel: _____
RCMP #: _____ Armed Forces #: _____
Other or Country Name: _____
Has this patient been seen previously by the NSHSC? Y ❑ N ❑
Where: _____ Chart #: _____

FAMILY DOCTOR
Name: _____
Address: _____
_____
Postal Code: _____ Tel: _____

REFERRAL SOURCE: _____
Company/Agency Name: _____
Address: _____
_____ Postal Code: _____
Tel: _____ Date: _____

SYMPTOMS/REASON FOR THIS REFERRAL:

RELEVANT MEDICAL DIAGNOSES:

Are there any **special procedures** for this case related to **cultural, language or accessibility considerations** (e.g., English not first language**,** mobility, vision, literacy)? ☐ YES ☐ NO

If yes, please describe:

Which **languages** are spoken at home?

REFERRAL FOR AUDIOLOGY:
☐ Complete Hearing Evaluation ☐ Hearing Screening ☐ Auditory Processing [must be ≥ 7 years old]

*** Evoked Potentials** ☐ ABR [Auditory Brainstem Response] ☐ Other _____
*** A current audiogram is required.** If possible, include results from Immittance

Are these services required for employment, insurance or pension purposes: ☐ YES ☐ NO If so, why?
NSHSC may refer to a specialist in Otolaryngology: ☐ YES ☐ NO

REFERRAL FOR SPEECH-LANGUAGE PATHOLOGY:
☐ Speech-Language Assessment ☐ Voice Assessment ☐ Dysphagia (swallowing) Assessment (where available)
☐ Other: _____

OPTIONAL:

I agree to the following person receiving information about my appointment at NSHSC:
_____ (name / position / relationship)
_____ (phone / address)

Client or Guardian _____ Date: _____
Name / Signature