Baycrest Audiology Physician Referral Form

Date: _____

The following individual is being referred to the Audiology department at Baycrest:

Patient Name: _____

Health Card (& Version#): _____ DOB: _____

Address: _____

_____

POA/Contact Name (other than patient): _____

Contact Phone/Email: _____

Reason for referral:

- ☐ Hearing Test
- ☐ Hearing Test + Hearing Aid Evaluation/Prescription
- ☐ Hearing Test + Hearing Aid Check

Additional notes: _____

_____

Referring Physician Information:

Physician Name: _____

Physician's Signature: _____

Physician Phone number: _____

Physician Billing number: _____

Please fax this form to Baycrest Audiology: **416-785-4213**

If you have any questions, please call or email Baycrest Audiology:

416-785-2476 or hearing@baycrest.org

Print Form | Email Form | Reset Form