Baycrest Audiology Physician Referral Form

Today's date: _____

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

Patient Name: _____

Health Card (& Version#): _____DOB: _____

Contact Name (if other than patient): _____

Contact Phone/Email: _____

Please fill out the following information about the referring physician

Physician Name: _____

Physician's Signature: _____

Physician Phone number: _____

Physician Billing number: _____

Any additional notes about the client: _____

_____

Please note: The clinicians at Baycrest specialize in interprofessional health care delivery. During your patient's assessment, should it be determined that they would benefit from consultation with another discipline, referral will automatically occur unless you check the box provided. ☐

Please fax this form to Baycrest Audiology: **416-785-4213**
or Email us at **hearing@baycrest.org**

If you have any questions, please call Baycrest Audiology:
416-785-2500 ex. 2377 or ex. 2476

Visit our new website!

www.baycrest.org/hearinghelp