Centre universitaire de santé McGill
McGill University Health Centre

☒ HME MCH ☐ HGM MGH ☐ HRV RVH
☐ HNM MNH ☐ ITM MCI ☐ CL LC

Montreal Children's Hospital

AUDIOLOGY Referral Form

1001, boul. Décarie, Room A.RC-4227
Montreal, Québec, H4A 3J1
Telephone: (514) 412- 4454
Fax: (514) 412- 4367 Email: audiologie.hme@muhc.mcgill.ca

Referral date (yyyy/mm/dd):

Patient Information (please print):

Date of birth (yyyy/mm/dd):	**MCH File no.**
Last name, First name	
Current address **City, Province** **Postal Code**	
Main telephone number	**Other telephone number**
Email	**Language** ☐ French ☐ English Other: _____ ☐ Interpreter needed

Please describe your concerns and age at referral:

Please note that we accept referrals for patients living on the island of Montreal ONLY, except for complex medical cases.

Referrals for newborn hearing screening must be sent BEFORE the age of 3 months.

Please check all that apply, even if no diagnosis has been made yet:

☐ **ASD concerns** ☐ Parents have been informed of the suspicion of autism
☐ **Speech/Language delay** *Specify:* _____
☐ **Child is on a waiting list for the following services** *Specify:* _____

☐ **Parents suspect a hearing loss**
☐ **Family history of hearing loss** *Specify:* _____
☐ **History of otitis media**
☐ **Central Auditory Processing evaluation has been recommended (7 y.o. and up only)**
☐ **Audiology evaluation done elsewhere: Please join report(s) if available**
- ☐ Failed hearing screening
- ☐ Incomplete evaluation
- ☐ Identified hearing loss; needs further assessment / follow-up needed
- ☐ Second opinion needed

☐ **Child presents a high risk of having a hearing loss:**
- ☐ Ototoxic medication ☐ Meningitis
- ☐ Cranio-facial abnormalities ☐ Complicated neonatal course: _____
- ☐ Any medical conditions associated with hearing loss : _____

Please indicate if child is receiving services: *Please specify coordinates*

☐ **CRDP** (Centre de réadaptation en déficience physique): _____
☐ **CRDI** (Centre de réadaptation en déficience intellectuelle): _____
☐ **CLSC / Agir Tôt:** _____
☐ **Youth Protection Services** (ex. DYP / Batshaw) ☐ **Actively followed** *Coordinates of community worker:* _____
☐ **Other:** _____

Referral Source:

Name of Referring Source: License number:
Address:
Telephone number: Fax number:
Name of Treating Physician (if different):
PARENTS ARE INFORMED OF THIS REFERRAL AND AGREE ☐ Signature:

PLEASE FAX OR EMAIL REFERRAL FORM TO:
Fax: 514-412-4367
Email: audiologie.hme@muhc.mcgill.ca