Client Name: _____ Phone: _____

Email: _____ Date of birth: ___ / ___ / _____ (DD / MM / YYYY)

Address: _____

City / Province / Postal Code: _____

Referral Date: ___ / ___ / _____ (DD / MM / YYYY)

REASON FOR REFERRAL

◯ *Hearing Assessment Adult*

◯ *Hearing Aid Consult*

◯ *Tinnitus Consult*

◯ *Custom Noise/Swim Earplugs*

◯ *Other*

Additional Comments:

Signed by: Dr. _____ /_____

Signature

◯ *Send report to the referring physician*

Katie Archie

Owner and Hearing Instrument Specialist

289-635-2337

www.burlingtonhearingcentre.com

info@burlingtonhearingcentre.com

3419 Fairview Street, Burlington, ON L7N 2R4

Please fax this referral to 289-635-2350 and a Burlington Hearing representative will call your patient to schedule an appointment