TORONTO HEAD & NECK CLINIC

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THN AUDIOLOGY
HEARING & BALANCE

☐ Audiometric or Vestibular Testing Only	☐ ENT Consult AND Diagnostic Testing	☐ ENT Consult only if Diagnostic Tests Abnormal	☐ ENT Consult + any advised Diagnostic Tests

PATIENT INFORMATION (or label)

Name: _____
Last First

Date of Birth: _____ ☐ Male ☐ Female
DD / MM / YYYY

Address: _____
Street # Street Name City Province Postal Code

Phone: _____ Alternate: _____

OHIP: _____
10 Digit # Version Code

TO BE COMPLETED BY REFERRING MD

Provisional Diagnosis / Reason for Test:

TMs Intact?	Right Ear ☐ Yes ☐ No	Left Ear ☐ Yes ☐ No
Audiometric Tests	☐ Basic Hearing Test	
	☐ Pediatric Hearing Test	
Advanced Audiometric & Vestibular Tests	☐ ABR (Auditory Brainstem Response)	
	☐ EcochG (Electrocochleography)	
	☐ VNG/ENG (Video/Electro-Nystagmography)	
	☐ VEMP (vestibular evoked myogenic potentials)	
	☐ Tinnitus Panel (Audio / ABR)	
	☐ Dizzy Battery (Audio / ABR / EcochG / VEMP / VNG)	
Hearing Aid Evaluation	☐ Consult	Non-OHIP. Please contact office for fees. May include hearing aid selection, assistive listening devices, communication training, counselling
Tinnitus Therapy	☐ Consult	Non-OHIP. Please contact our office for fees, options and programs

REFERRING PHYSICIAN INFORMATION (or Stamp)

Name: _____ Physician #: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____