Physician Referral Request

2489 Bloor Street West, Suite 301
Toronto, ON, M6R 1S6
Phone: (416) 760-7060 Fax: (416) 767-8484

Supervising Otolaryngologist: Dr. Rick Fox

PATIENT'S INFORMATION

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

Date of Birth: _____ SEX: ____ H.C. # _____ VC: ____

TELEPHONE (Home): _____ MOBILE: _____

DIAGNOSIS/REASON FOR ASSESSMENT:

_____

_____

Please select all applicable below:

- **REQUIRES WAX REMOVAL BY OTOLARYNGOLOGIST – appointment will be made on the same day (before the hearing test is done)**
- **DO NOT seek Otolaryngology intervention (when appropriate) before returning the patient to my care.**
- **DO NOT refer this patient to the Infant Screening Program (if indicated) before returning the patient to my care.**

Results for these tests should be faxed to (fax number): _____

Doctor's Name: _____ Physician OHIP billing #: _____

Address: _____

Phone: _____ Signature: _____

Patients require a physician's referral in order to obtain an insured hearing test. All tests are reviewed by the supervising otolaryngologist.