## LAST NAME MIDDLE NAME FIRST NAME Scarborough **ADDRESS** APARTMENT No. **PROVINCE** CITY POSTAL CODE Hearing and Balance Centre HOME TELEPHONE OTHER TELEPHONE ) REQUEST FOR EMAIL: CONSULTATION DATE OF BIRTH (DD/MM/YY) SEX Scarborough ☐ MALE FEMALE Hearing and Balance Centre 1415 Kennedy Rd., Unit 6 HEALTH CARD No. VERSION CODE Scarborough, ON M1P 2L6 Tel: 647-748-2999 Fax: 647-748-4999 REFERRING PHYSICIAN Email: shbcentre@gmail.com www.hearingandbalancecentre.com APPOINTMENT DATE TIME LANGUAGE SPOKEN: **DIAGNOSIS / REASON FOR REFERRAL:** □ AUDIOLOGY □ ENT ☑ PROCEDURES REQUESTED (Battery of tests may vary according to the age and primary concern) DIZZY TEST BATTERY \*\*New\*\* ☐ Hearing Test ☐ Pediatric Hearing Test (>5 yrs) <sup>①</sup> Includes the tests below Audio/Sound Field/Impedence/Screening OAE □ Advanced Diagnostic Hearing Tests □ OAE (Otoacoustic Emissions) (includes ABR) □ Cerumen Removal\* ☐ EcochG (Electrocochleography) ☐ Tinnitus Assessment (Audio/ABR/VEMP) Meniere's Disease/Labrynthine hydrops □ cVEMP (Cervical Vestibular Evoked ☐ Tinnitus Management\* Myogenic Potentials) ☐ ABR (Auditory BrainStem Response) site of lesion/thresholds □ oVEMP (Ocular Vestibular Evoked Myogenic Potentials)

## \*SPECIAL INSTRUCTIONS

□ VAT (Vestibular Autorotation Test)

□ ENG (Electronystagmography)\*\*New\*\* Please see reverse for instructions.

- ❖ Pediatric Testing: An adult is required to accompany children under 5 years of age into the testing room and any other young children are not to be left unattended.
- Location: Please see reverse for details.

☐ HAE (Hearing Aid Evaluation)\*

□ HAC (Hearing Aid Check)\*

\*Charge applies

- ♦ Patients arriving late or without a valid health card may be rescheduled.
- ♦ Kindly give at least 24 hours notice for cancellations.