

Sudden Sensorineural Hearing Loss Referral

- Submit referral by Fax: **403-592-4289**
- All referrals must include a **recent audiogram** performed after the reported hearing loss occurred.
- **Incomplete referrals will be faxed back to the referral source without being triaged.**
- Our office will contact the patient with an appointment. Please **do not call** our office for an appointment date.

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name ☐ Last ☐ First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI ☐ Same as PHN	MRN	
Administrative Gender ☐ Male ☐ Female ☐ Unknown ☐ Non-binary/Prefer not to disclose (X)			

Hearing Loss Onset							
Hearing Loss Date of Onset <i>(dd-Mon-yyyy)</i>			Date First Seen by Non-ENT Physician <i>(FP, ED, etc.)</i>			Date of Diagnostic Audiogram <i>(dd-Mon-yyyy)</i>	
Ear(s) Affected ☐ Left ☐ Right ☐ Both							
Appropriate Referrals 1. Greater than 30 dB sensorineural decline at 3 or more consecutive frequencies 2. Hearing loss onset less than or equal to 3 weeks (Urgent) 3. Hearing loss onset between 3 – 12 weeks (Semi-urgent)				Inappropriate Referrals 1. Less than 30 dB sensorineural decline at less than 3 consecutive frequencies 2. Hearing loss onset greater than 12 weeks 3. Conductive hearing loss			
Patient Information							
Last Name			First Name			PHN	
Date of Birth <i>(dd-Mon-yyyy)</i>		Address			City/Town		Postal Code
Name Parent/Guardian <i>(if applicable)</i>				Home Phone		Alternate Phone	
Family Physician <i>(Last Name, First Name)</i>				Phone		Fax	
Interpreter required? ☐ Yes ☐ No ▶ Specify language _____							
Medical and Audiological History							
Tinnitus	☐ Yes ☐ No	▶ ☐ New ☐ Pre-existing ☐ Left ☐ Right ☐ Both Onset _____					
Vertigo/dizziness	☐ Yes ☐ No	▶ ☐ New ☐ Pre-existing ☐ Episodic ☐ Constant Onset _____					
Aural fullness	☐ Yes ☐ No	▶ ☐ New ☐ Pre-existing ☐ Left ☐ Right ☐ Both					
Pre-existing hearing loss	☐ Yes ☐ No	▶ ☐ Left ☐ Right ☐ Both Cause _____					
Noise exposure/history	☐ Yes ☐ No	▶ ☐ Work-related ☐ Recreational Number of hours/day _____					
Recent head injury (<i>< 1 yr</i>)	☐ Yes ☐ No	Date	Recent ear trauma (<i>< 1 yr</i>)		☐ Yes ☐ No	Date	
Recent ear infection	☐ Yes ☐ No	Date	URTI in preceding weeks		☐ Yes ☐ No		
Ear pain (otalgia)	☐ Yes ☐ No		Prior ear surgery		☐ Yes ☐ No		
Otologic history ☐ Recurrent acute otitis media ☐ Chronic otitis media ☐ Family history of otologic disease (excluding age-related hearing loss)							
Relevant medical history ☐ Autoimmune disease ☐ Cardiac history ☐ Stroke ☐ High cholesterol ☐ Angina ☐ Other _____							
Smoking ☐ Yes ☐ No ☐ Prev. /day _____			Cannabis ☐ Yes ☐ No ☐ Prev.			Alcohol ☐ Yes ☐ No ☐ Prev. /wk _____	
Prescribed medications <i>(please list all or attach list)</i>							
*Oral steroids started (e.g. prednisone)? ☐ Yes ☐ No ▶ Steroid, dose & duration _____							
Start date _____ Anticipated date of completion _____							
Referral Source							
Referral Date <i>(dd-Mon-yyyy)</i>		Name Physician/Audiologist				Signature	
Practice ID	Fax	Phone			Address		