MARKHAM STOUFFVILLE HOSPITAL
CHILD DEVELOPMENT PROGRAMS

Confidential

TRI-REGIONAL INFANT HEARING PROGRAM REFERRAL FORM

Instructions: Fax to 905-472-7553 or mail to the address at bottom of this page.

REFERRAL SOURCE INFORMATION

REFERRED BY (name):	**DATE OF REFERRAL:**
TITLE (if applicable):	**TEL NO. and EXT:**
ORGANIZATION:	**FAX NO:**

I have received the verbal consent of the parent or legal guardian to make this referral on their behalf.
Signature:

CLIENT INFORMATION

Child's Name:			☐ Male ☐ Female
DOB:			
Mothers Name:			
Father's Name:			
Address of Child:		Town:	Postal Code:
Day-time Telephone:		Other Tel:	
Did child pass the newborn infant hearing screening?		☐ No ☐ Yes ☐ Do not know	
Is child currently enrolled with an Infant Hearing Program?		☐ No ☐ Yes, in _____ Region	

Service Language ☐ English ☐ French ☐ Other (include dialect)_____

REASON FOR REFERRAL

☐ **Baby under 4 months corrected age – request hearing screen as baby not screened at birth**

☐ **Permanent childhood hearing loss identified by an audiologist**
Date of Diagnosis: _____ Attach most recent audiogram.
Name of audiologist: _____ IHP Trained ☐ Yes ☐ No

☐ **Child has a risk factor for permanent childhood hearing loss**
(Please note that otitis media or speech/language delay are not risk indicators by themselves)
☐ Post-natal infection associated with hearing loss including meningitis, viral encephalitis or labyrinthitis.
Date of Diagnosis: _____
☐ Family history of permanent childhood hearing loss. List relationship to infant: _____
☐ Diagnosis of a syndrome associated with permanent hearing loss. Specify: _____
☐ Physician has identified a permanent hearing loss through assessment.
☐ Significant head trauma associated with loss of consciousness or skull fracture.
☐ Other factor associated with permanent childhood hearing impairment (please describe).
_____

REFERRAL OUTCOME (completed by Intake Coordinator and faxed to referral source)

☐ Referral not accepted – reason _____
☐ Child under 4 months corrected – forward to Booking Clerk for community screen in Region _____
☐ Child under 12 months corrected – forward to Audio Booking for High Risk Surveillance & open file
☐ Refer to IHP audiology for PHL confirmation – forward to Audio Booking & open pending chart

ISCIS Entry Required: ☐ NO ☐ YES, Entered on date: _____ By: _____