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 the 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 (first and last):			
DOB: ☐ Male ☐ Female			
Mothers Name (first and last):			
Father's Name (first and last):			
Address of Child:		Town:	Postal Code:
Day-time Telephone:	Other Telephone:	Email:	
In which hospital was the baby born?			
Did child pass the newborn infant hearing screening? ☐ No ☐ Yes ☐ Do not know			
Is child currently enrolled with an Infant Hearing Program? ☐ No ☐ Yes, Region:			
Service Language: ☐ English ☐ French ☐ Other (include dialect):			

REASON FOR REFERRAL

☐ **Baby under 3 months corrected age – requesting hearing screen as baby not screened at birth**

☐ **Permanent childhood hearing loss identified by an audiologist.** Please attach most recent audiogram.
Date of Diagnosis: _____ 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. 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 loss (please describe):
  _____

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

☐ Referral not accepted – reason _____
☐ Child under 3 months corrected – to be scheduled for community screen
☐ Child under 12 months corrected – to be scheduled for High Risk Audiology Surveillance
☐ Refer to IHP audiology for PHL confirmation – to be scheduled for Diagnostic Audiology

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