Child Development Programs
Administered by Markham Stouffville Hospital

Tri-Regional Infant Hearing Program
Referral Form

Confidential

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:
Birth Hospital:		
Did child pass the newborn infant hearing screen? ☐ No ☐ Yes ☐ Do not know		
Is child currently enrolled with the Infant Hearing Program (IHP)? ☐ No ☐ Yes, Region:		
Service Language: ☐ English ☐ French ☐ Other (include dialect):		

REASON FOR REFERRAL

☐ **Baby under 2 months corrected age** – requesting hearing screen as baby not screened at birth

☐ **Permanent hearing loss identified by an audiologist.** Please attach most recent audiogram.
Date of Identification: _____ Audiologist: _____

☐ **Child has a risk factor for permanent hearing loss**
***Please note that ear infections or a speech/language delay are not sufficient to qualify for service ***

- ☐ Post-natal infection associated with permanent hearing loss including meningitis, viral encephalitis or labyrinthitis.
  Date of Diagnosis: _____
- ☐ Diagnosis of a syndrome associated with permanent hearing loss (PHL). Specify: _____
- ☐ Physician has identified a PHL through assessment.
- ☐ Significant head trauma associated with loss of consciousness or skull fracture.
- ☐ Other factor associated with PHL (please describe):
  _____

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

☐ Referral **NOT** accepted
- ☐ Please provide additional information to confirm eligibility for service.
- ☐ Child does not meet eligibility criteria. Please refer to a local audiology clinic.

☐ To be scheduled for community screen
☐ To be scheduled for audiology assessment