Dr. Allan Ho #137, 501 BETHEL DRIVE, SYNERGY WELLNESS CENTRE, SHERWOOD PARK, AB
Phone #: (780) 570-5494 ext 0 Fax #: (780) 570-5493

REFERRAL FORM

REFERRING PHYSICIAN:
ADDRESS:
PRACID:
Fax #:

Date:

Dear Dr. Allan Ho:

Thank you for accepting to see the following patient:
PATIENT INFORMATION: (*NAME, *ADDRESS, *TELEPHONE #, *EMAIL ADDRESS, *DOB,*PHN)

☐ **Potential Cochlear Implant Candidate** ☐ **Sudden-Onset Hearing Loss**

	Onset		Side	Side
Symptoms	**Sudden (within 72 Hours)**	**Gradual (State weeks to years)**	**Right**	**Left**
Hearing Loss				
Otorrhea				
Otalgia				

If otalgia is the main symptom: Please check that the following have been excluded:

Conditions causing referred otalgia	Please tick the box if the condition has been excluded
TMJ	
Dental Pathology	
Musculoskeletal Neck Pathology	

Other Symptoms: _____

☐ **Ear Health Clinic**

...2

Pertinent signs on Physical Examination: _____

_____

If dizziness is the main symptom: Please give us an accurate description of dizziness:

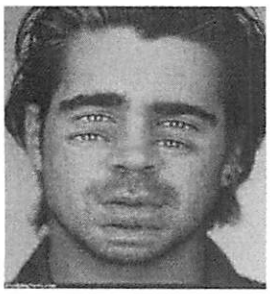
_____

_____

_____

_____

☐ True Vertigo with nausea: Please check this if it is true hallucination of movement.



You must check off each description of General Dizziness as you exclude or Include it:	Yes	No
Lightheadedness without nausea		
Headaches includes foggy-headedness with migraine-type auras		
Presyncopal includes vasovagal, blackouts, palpitations		
Unsteadiness, Imbalance		
Other: Please Describe		

Duration of dizziness of the dizzy episode (do not include the pre- or post-attack hangover period)	Check off only one below:
Seconds to minutes	
Hours	
Days to weeks	
Constant dizziness, all the time, no attacks/episodes	