THE EAR CLINIC

Dr. ALLAN HO

#137, 501 BETHEL DRIVE, SYNERGY WELLNESS CENTRE, SHERWWOD PARK, AB
Phone #: (780)570-5494 ext 0 or Fax #: (780) 570-5493

REFERRAL FORM

REFERRING PHYSICIAN:
ADDRESS/CLINIC NAME:
PRACID:
FAX #:

Date:

Dear Dr. Allan Ho:

Thank you for accepting to see the following patient:
PATIENT INFORMATIOM: (*Name, *Address, *Telephone No.,*E-mail address,*DOB, *PHN)

REASONS FOR REFERRAL:_____

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

	Onset	Duration	Side	Side
Symptoms	**Sudden (within 72 hours)**	**Gradual (state weeks to years)**	**Right**	**Left**
Hearing Loss				
Otorrhea				

OTHER PERTINENT SYMPTOMS ON PHYSICAL EXAMINATION:

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☐ **ALL Audiological results attached;**

☐ **IMAGING PERFORMED** ☐ **CT Temp Bones** ☐ **MRI IAC**

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