



Sabrina DeToma, Au.D.
Doctor of Audiology, Audiologist
Maple Gate Medical Building
2200 Rutherford Road, Suite 202
Tel. **905-303-4327**

REFERRAL FORM

Referral Source Information

Today's Date: _____ Physician Name: _____

Address Stamp Here

Client Information

Client First Name: _____ Client Last Name: _____

Address: _____ City/Town: _____

Postal Code: _____ Province: _____

Date of Birth/Age: _____ Gender: Male Female

Home Phone: _____ Alternate Phone: _____

Reason for Referral

- | | | |
|---|--|--|
| <input type="checkbox"/> Hearing Test | <input type="checkbox"/> Noises in Ears/Head (Tinnitus) | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Sensitive to sounds (Hyperacusis) | <input type="checkbox"/> Custom earplugs (swimming or noise) |
| <input type="checkbox"/> Auditory Processing Assessment | <input type="checkbox"/> Ear wax removal | <input type="checkbox"/> _____ |

Notes

Please fax referrals to **905-303-3188**