Bone Conduction Implant Program Referral Form

Hearing Implant Services
Room 1D 20, 4480 Oak Street, Vancouver, BC, V6H 3V4
Fax: 604-875-2977 **Phone:** 604-875-2345 ext. 5239

INCOMPLETE REFERRALS WILL BE RETURNED

Patient information

Last name	**First name**	**Referral date** (dd/mm/yyyy)
DOB (dd/mm/yyyy)	**BCCH MRN**	**BC PHN** (care card)

Preferred pronouns ☐ She/her ☐ He/him ☐ They/them	**Language** ☐ English ☐ Other	**Interpreter required?** ☐ No ☐ Yes **Language**

Mailing address (number/street/apt.)	**City/town**	**Postal code**
Family physician/pediatrician	**Physician phone**	

Parent(s), legal guardian(s) and/or caregiver(s)

Last name	**First name**	**Relationship**	**Phone**	**Email**	**Legal guardian?**
					☐ Yes
					☐ Yes

Referral source (mandatory)

Last name	**First name**	**MSP billing #**
Phone	**Email**	**Fax**
Mailing address (number/street/apt.)	**City/town**	**Postal code**

Type of referral (please complete ALL relevant boxes)

☐ Bone Implant Candidacy Assessment (must meet referral requirements)

☐ Informational only (referral for candidacy must be initiated once requirements met)

Referral requirements (checklist)

☐ Age 5+ years

☐ Referral to Bone Conduction Implant Program ENT

☐ Etiology – audiologic history enclosed

- ☐ Air conduction thresholds
- ☐ Bone conduction thresholds (masked AND unmasked)
- ☐ Aided NBN/warble tone thresholds & Ling 6 thresholds

Non-implantable Bone Conduction Device Trial

☐ Softband ☐ Soundarc

Make & model:

Fit date (dd/mm/yyyy):

Length of trial:

Other relevant information (please attach additional page if necessary)

FAX COMPLETED FORM TO 604-875-2977