AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY DEPARTMENT
Cochlear Implant Services

PROGRAM TRANSFER - INTAKE FORM Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Parent(s) & Phone Number and/or Email: _____

Current Provincial Health Care #: _____

Implant Centre _____ Dept. Phone: _____

Surgeon: _____ CI Audiologist _____

Date of Implantation & Ser #: Right_____ Left: _____

Implant Manufacturer: ☐ Cochlear ☐ Med El ☐ Advanced Bionics

Sound Processor Model & Ser #: Right: _____ Left: _____

Medical Issues or Complications of Note: _____

_____

Mode of Communication: _____

Current Habilitation Program/School: _____

Month/Year started _____ Habilitationist/Teacher _____

The following to be requested from previous implant centre. Please fax or mail to our address below:

☐ *Pre-CI and Post–CI Reports & Audiograms* ☐ *Ccopy of electronic mapping files*

☐ *Most recent Habilitationist/Therapist reports* ☐ *Meningitis Vaccine Documentation*

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