**AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY DEPARTMENT**
***Cochlear Implant Services***

**PROGRAM TRANSFER - INTAKE FORM** Date: ______________________________

Patient Name: _______________________________________ Date of Birth: __________________________

Preferred Name: _______________________________________________ Gender: ___________________

Address: ___________________________________________________________________________________

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

Primary Language used at home (including ASL): ____________________ Interpreter Required? Yes No

Provincial Health Care #: ________________________________________________________

Current Family Physician/ Pediatrician: _________________________________________________________

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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: __________________________________________________________________

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Current Habilitation Program/School: ________________________________________________________

Month/Year started:________________________ Habilitationist/Teacher:__________________________

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

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

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

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