COCHLEAR IMPLANT REFERRAL FORM (Oct 2024)

Audiology Department ☐ **THIS IS AN INQUIRY ONLY**

Phone: 604-875-2345 ext 5239 Fax : 604 875-2977

Referring Doctor/ Audiologist Details

Name:_____ Referral Date:_____

Telephone: _____ Fax:_____ Email:_____

Address:_____

I have explained to the parent/guardian that this referral is for a CI candidacy consultation only and does not necessarily mean that a cochlear implant will be recommended. **Signature**:_____

Patient Information

Child's Name: _____ D.O.B: _____ Gender: _____

P.H.N.: _____ Government funding: Healthy Kids, Income Assistance, At Home etc?

Parent/Guardian Names: _____

Address: _____ City: _____ Postal Code: _____

Telephone Number(s):_____ Email:_____

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

Hearing Loss and Amplification History

Either enclose a report with the following information OR complete the following:

When Hearing Loss was first Identified:	R: L:	Where HL was diagnosed:	(Which clinic? Another country?)
Degree & progression of HL:			
Etiology:			
Date of Hearing Aid(s) first fit:	R: L:	Current HA(s) (make, model):	R: L:
Datalog of HA use (hrs/day):	R: L: (Note: Inconsistent HA use can affect CI candidacy)		
Aided speech perception scores	R: (at 60 dB SPL, L: masking as needed)	Primary mode of communication:	(Aural/oral? ASL? Total Communication? Cued Speech? Gestures?)

Additional Info: _____

_____

Other Providers

Family Physician/ Pediatrician: _____

Early Interventionist/Hearing Resource Teacher: _____

Preschool/School: _____

To complete this referral:

- ❑ Submit this referral form
- ❑ Include audiograms with AC and BC thresholds, reports & current REMS
- ❑ ANSD cases: Behavioural thresholds and SLP reports
- ❑ Send *Physician Letter for CI ENT Referral* to family doctor's office
- ❑ Submit referral in BEST (if applicable)

Submit full documentation by fax or mail. Incomplete referrals will not be accepted.

Fax: 604 875-2977 or
BCCH Internal 2977

BC Children's Hospital
Cochlear Implant
Room 1D20, 4480 Oak Street
Vancouver, BC V6H 3V4

Clinic contact information
Address:
Tel:
Fax:

RE: LAST, First
DOB: Day Month Year
BC PHN:

RE: Referral has been made to BC Children's Hospital Cochlear Implant Surgeons

Dear Dr. [insert name of family doctor/pediatrician/nurse practitioner],
This patient may be a candidate for cochlear implant(s). To expedite further investigation and care, a referral to the Otolaryngologists on the Cochlear Implant Team at BC Children's Hospital has been initiated on your behalf.
As the family has identified you as their primary care provider, you will be copied on the results of the medical investigations completed.
If you have any concerns about this referral please contact Dr. Mark Felton and/or Dr. Amjad Tobia.

Sincerely,

_____
[NAME], M.Sc., R.AUD

cc: BC Children's Hospital Otolaryngology Department, attn: Dr. M. Felton/Dr. A. Tobia