COCHLEAR IMPLANT REFERRAL FORM (Jul 2024)

Audiology Department

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

Referring Doctor/ Audiologist Details

Name:_____ Referral Date:_____

Telephone: _____ Fax:_____ Email:_____

Address:_____

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

Has the parent/guardian been notified prior to CI referral? Yes No OR ☐ **INQUIRY ONLY**

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 (required)
- ❑ Include audiograms, reports & current REMS (required)
- ❑ Submit referral in BEST (if applicable)
- ❑ Initiate referral to BCCH CI surgeon
  (Dr. Tobia/ Dr. Felton at F: 604 875 2498)

Submit full documentation by fax or mail.

Fax: 604 875-2977 or
BCCH Internal 2977

BC Children's Hospital
Cochlear Implant
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Vancouver, BC V6H 3V4