HEARING & SPEECH NOVA SCOTIA REFERRAL

1-888-780-3330 (Call for information)
www.hearingandspeech.ca

Hospital card imprint

Name: Last _____ First _____ Middle _____

Date of Birth: _____/_____/_____ Pronouns: ❑ He/Him ❑ She/Her ❑ They/Them ❑ _____
d m y

Address: _____

Apt. #: _____ City: _____ Province: _____ Postal Code: _____

Cell #: _____ Home #:_____

Alternate Contact: _____ Relationship: _____ Tel: _____

Health #: _____ Province: NS ❑ or _____ Expiry Date: _____/_____/_____

RCMP #: _____ Armed Forces #: _____ Country Name: _____

PERSON REFERRING: Date: _____

❑ SELF (address above)

❑ Other: _____

Address: _____

Postal Code: _____ Tel: _____

FAMILY DOCTOR or NURSE PRACTITIONER (if you have one)

Name: _____

Address: _____

Postal Code: _____

Tel: _____ Fax: _____

DESCRIBE YOUR CONCERNS/REASON FOR REFERRING:

REFERRAL FOR SPEECH-LANGUAGE PATHOLOGY:

☐ Speech-Language Assessment (includes Hearing Screening)

☐ Dysphagia (swallowing) Assessment (where available) ☐ Voice Assessment

☐ Other/Don't Know: _____

REFERRAL FOR AUDIOLOGY:

☐ Complete Hearing Evaluation ☐ Auditory Processing [must be 7 years or older]

☐ Hearing Screening ☐ Auditory Brainstem Response (ABR)

☐ Other/Don't Know: _____

Is there anything Hearing & Speech Nova Scotia should know to prepare for the assessment?
E.g. interpreter/translator required**,** mobility, vision, or literacy challenges?
If yes, please describe:

Which **languages** are spoken at home?