



**REFERRAL**

1-888-780-3330 (call for information)  
[www.nshsc.nshealth.ca](http://www.nshsc.nshealth.ca)

Hospital card imprint

Name: Last \_\_\_\_\_  
 First \_\_\_\_\_ Middle \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M  F   
d m y  
 Address: \_\_\_\_\_  
 Apt. #: \_\_\_\_\_ City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Tel: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Health #: \_\_\_\_\_  
 Province: NS  or \_\_\_\_\_ Expiry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Next of Kin: \_\_\_\_\_ Tel: \_\_\_\_\_  
 RCMP #: \_\_\_\_\_ Armed Forces #: \_\_\_\_\_  
 Other or Country Name: \_\_\_\_\_  
 Has this patient been seen previously by the NSHSC? Y  N   
 Where: \_\_\_\_\_ Chart #: \_\_\_\_\_

**FAMILY DOCTOR**  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Tel: \_\_\_\_\_

**REFERRAL SOURCE:** \_\_\_\_\_  
 Company/Agency Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Tel: \_\_\_\_\_ Date: \_\_\_\_\_

**SYMPTOMS/REASON FOR THIS REFERRAL:**  
 \_\_\_\_\_  
**RELEVANT MEDICAL DIAGNOSES:**  
 \_\_\_\_\_

Are there any **special procedures** for this case related to **cultural, language or accessibility considerations** (e.g., English not first language, mobility, vision, literacy)?  YES  NO  
 If yes, please describe:  
 Which **languages** are spoken at home?

**REFERRAL FOR AUDIOLOGY:**  
 Complete Hearing Evaluation  Hearing Screening  Auditory Processing [must be  $\geq 7$  years old]  
 \* **Evoked Potentials**  ABR [Auditory Brainstem Response]  Other \_\_\_\_\_  
 \* **A current audiogram is required.** If possible, include results from Immittance  
**Are these services required for employment, insurance or pension purposes:**  YES  NO **If so, why?**  
 NSHSC may refer to a specialist in Otolaryngology:  YES  NO

**REFERRAL FOR SPEECH-LANGUAGE PATHOLOGY:**  
 Speech-Language Assessment  Voice Assessment  Dysphagia (swallowing) Assessment (where available)  
 Other: \_\_\_\_\_

**OPTIONAL:**  
 I agree to the following person receiving information about my appointment at NSHSC:  
 \_\_\_\_\_ (name / position / relationship)  
 \_\_\_\_\_ (phone / address)  
 Client or Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_  
*Name / Signature*