HEARING HEALTHCARE
PATIENT REFERRAL

Patient name:_____

Location: _____

Tel:_____ Email:_____

Referred for:

- ❑ Diagnostic Hearing Test & Assessment
- ❑ Hearing Aid Consultation/Recommendation
- ❑ Hearing Aid Repair
- ❑ Hearing Aid Adjustment
- ❑ Cerumen Management
- ❑ Hearing Protection
- ❑ Other_____

_____

Referral by: _____

Appointment Scheduled:

Date: _____ Time: _____

HOMETOWN
HEARING CENTRE

YOUR HOMETOWN CHOICE

info@hometownhearing.ca **www.hometownhearing.ca**