SUDBURY
HYPERBARICS & WOUND CARE

REFERRAL FORM FOR SUDDEN SENSORINEURAL HEARING LOSS

Please send URGENT referrals to admin@sudburyhbot.ca

PATIENT INFORMATION

Full Name:_____ DOB:_____
First Last DD/MM/YYYY

Email Address:_____ Phone Number: _____

OHIP No. with Version Code: _____

Primary Care Physician: _____ Initial Onset of Symptoms: _____

CORTICOSTEROID THERAPY STARTED

YES, Rx and Start Date: _____ **No**

HISTORY

_____

PLEASE INCLUDE ALL OF THE FOLLOWING INFORMATION WITH YOUR REFERRAL (IF AVAILABLE):

- Audiology Report
- MRI PFTS ECG
-
-
- CXR
- Recent Bloodwork
- Past Medical/Surgical History
- List of Medications and Allergies

REFERRING PHYSICIAN INFORMATION

Name: _____ Tel: _____

OHIP #: _____ Fax: _____

CPSO #: _____ Date: _____

Signature: _____

2009 Long Lake Rd Rd, Unit 1B, Sudbury, ON P3E 6C3 P: 705-806-8277 | F: 705-885-3207 |
E: admin@sudburyhbot.ca | W: sudburyhbot.ca