CANADIAN HEARING SERVICES

Referral Form
for External Agencies

Voice: 1-866-518-0000 • **TTY:** 1-877-215-9530 • **Fax:** 1-866-781-8999

I. REFERRAL DETAILS

☐ The applicant or lawfully authorized substitute decision maker has consented to this referral.

Date: _____

Name: _____ Agency: _____

Relationship: _____ Telephone: _____

Email: _____ Fax: _____

Referral to Audiology: **FAX:** 1-855-259-8152 **E-MAIL:** audiology@chs.ca

☐ Hearing Test/Hearing Aids ☐ Tinnitus/Hyperacusis ☐ Aural Rehabilitation

☐ Speech Language Pathology ☐ Other: _____

Referral to Counselling: **FAX:** 1-866-781-8999

E-MAIL: connectmentalhealth@chs.ca • generalsupportservices@chs.ca • hearingcarecounselling@chs.ca

☐ CONNECT Mental Health ☐ General Support Services

☐ Hearing Care Counselling ☐ Settlement Program for Newcomers

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Referral for Employment: **FAX:** 1-855-259-8152 **E-MAIL:** employmentservices@chs.ca

☐ Job Seeker ☐ Workplace Assessment ☐ Other: _____

Referral for Educational: **FAX:** 1-855-259-7809 **E-MAIL:** literacytraining@chs.ca

☐ Literacy and Basic Skills ☐ ASL Education (Sign Language Services)

☐ Language Instruction for Newcomers (LINC)

Referral for Deafblind Services: **FAX:** 1-833-842-4255 **E-MAIL:** deafblindservices@chs.ca

II. CLIENT DEMOGRAPHICS

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ ☐ Landline ☐ Mobile

☐ TTY ☐ Voice ☐ VRS ☐ Text

Email Address:

Preferred Language: ☐ English ☐ French ☐ Other: _____

OHIP: _____ Version code: _____

Has client been to CHS before? ☐ Yes ☐ No

Which location: _____ Which program? _____

When? _____ Counsellor's name? _____

III. HEARING HEALTH:

Hearing Status:

- ☐ Deaf
- ☐ Deafened
- ☐ Oral Deaf
- ☐ Deafblind
- ☐ Hard of Hearing
- ☐ Hearing

Communication preference:

- ☐ Interpreter
- ☐ Deaf interpreter
- ☐ Voice
- ☐ Note taker
- ☐ Transcription

Contact preference:

- ☐ Phone
- ☐ TTY
- ☐ Text message
- ☐ E-mail
- ☐ mail

IV. ALTERNATE CONTACT:

Name: _____ Relationship to Client: _____

Phone number: _____ ☐ Mobile ☐ Landline ☐ Text ☐ TTY

Email Address: _____

V. REASON FOR REFERRAL:

Presenting concerns or services requested:

Additional Information - please note or attach information that may be helpful in providing service (eg. diagnosis, audiogram, disabilities, counselling history, technical devices used, medications)