Physician Referral

Connect Hearing

PATIENT NAME: _____

PATIENT PHONE: _____

REASON FOR REFERRAL:

**Fees apply*

- ☐ Complimentary hearing screening (no report)
- ☐ Diagnostic assessment + report*
- ☐ Hearing aid assessment
- ☐ Tinnitus assessment + report*
- ☐ Hearing test for employment*

COMMENTS: _____

REFERRING PHYSICIAN: _____

PHYSICIAN SIGNATURE: _____

REFERRAL DATE: _____

Please call 1.888.242.4892 or go to connecthearing.ca to book an appointment at your local Connect Hearing clinic. Bring this form with you to your appointment.

☐ Physicians please check this box if more referral pads are needed at your office.