SAMPLE TEMPLATE — FOR DESIGN DEMONSTRATION ONLY. THIS IS NOT THE CLINIC'S OFFICIAL REFERRAL FORM.

Bionic Hearing Hub

Physician Referral Form · Hearing Healthcare · Whitby, Ontario

Patient Information

PATIENT FULL NAME

DATE OF BIRTH

PATIENT PHONE

HEALTH CARD NO. (OPTIONAL)

Reason for Referral

☐ Hearing assessment

☐ Hearing aid consultation

☐ Follow-up hearing care

☐ Other (please note below)

RELEVANT HISTORY / NOTES

Referring Physician

PHYSICIAN NAME

PHONE / FAX

PRACTICE / CLINIC

DATE

SIGNATURE