

## Patient Information

Name \_\_\_\_\_ Referral Date \_\_\_\_\_  
First Name Last Name DD/MM/YYYY

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_  
DD/MM/YYYY

Address \_\_\_\_\_

Health # \_\_\_\_\_ Contact # \_\_\_\_\_  Mobile  Home

Preferred Language

English  Cantonese  Mandarin  Other : \_\_\_\_\_

## Physician Information

Referring Physician \_\_\_\_\_  
First Name Last Name

Clinic Name \_\_\_\_\_ Physician Signature \_\_\_\_\_

I am prescribing the following treatment(s) for the above mentioned patient

- Hearing Test and Report 
 If further medical investigation is required, please forward referral to People Hearing's partner ENT
- Tinnitus Assessment (\$150)
- Wax Removal (\$40/15 mins)
- Hearing Test for Employment
- Hearing Aids
- Other : \_\_\_\_\_

### Office Stamp :

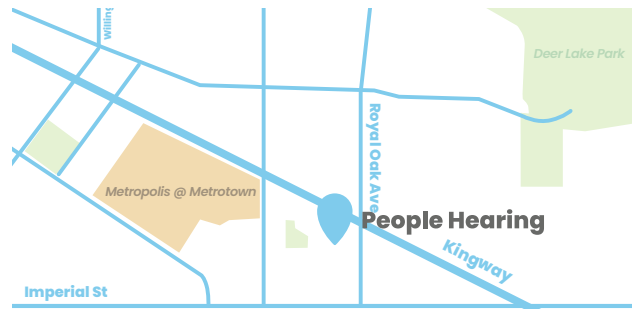
Clinic Name : \_\_\_\_\_

Clinic Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### **Metrotown**

#140B - 6540 Burlington Ave, Burnaby, BC V5H 4G3

**T:** 604.434.2070 **F:** 604.434.2076 **E:** burnaby@peoplehearing.com



### Remarks :

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### Language Support :

English & Cantonese & Mandarin