503 Main St.
Esterhazy, SK
S0A 0X0
P: (306) 745-2117
F: (306) 745-2118

Email: chelsea@myhouseofhearing.ca Web: www.myhouseofhearing.ca

Patient Name:_____

Address:_____ City:_____

Date of Birth:_____ Telephone:_____

Date of Referral:_____

Parent / Guardian: _____

Reason for Referral:

- ☐ Tinnitus (Ringing in Ears)
- ☐ Dizziness / Vertigo
- ☐ Hearing Evaluation / Fitting
- ☐ Hearing Concern
- ☐ Custom Hearing Protection
- ☐ Other (Please specify below)

Additional Comments:

_____

_____

_____

Referral Source:

Name:_____ Signature:_____

Address:_____

Phone:_____ Fax:_____