YORK HYPERBARIC MEDICINE CENTRE

1773 Leslie St, Unit 112
Newmarket, ON L3Y 3E4

HBOT REFERRAL FORM FOR SUDDEN SENSORINEURAL HEARING LOSS

PATIENT INFORMATION

Full Name: ____ DOB: ____
First Last DD/MM/YYYY

Email Address: ____________________________________ Phone Number: ________________________________

OHIP No. with Version Code: ____

Primary Care Physician: ___________________________ Initial Onset of Symptoms: ________________________

CORTICOSTEROID THERAPY STARTED

☐ **YES, Rx and Start Date:** _________________________________ ☐ **No**

HISTORY

____

REFERRING PHYSICIAN INFORMATION

Name: ____ Tel: ____

OHIP #: ____ Fax: ____

CPSO #: ____ Date: ____

Signature: ____

PLEASE INCLUDE THE PATIENT'S AUDIOLOGY REPORT

If available, please include the following:

- CXR
- MRI
- PFTS
- ECG
- Recent Bloodwork
- Past Medical/Surgical History
- List of Medications
- List of Allergies

Please send URGENT referrals to ISSNHL@yorkhbot.com