



Voice: 1-866-518-0000 • TTY: 1-877-215-9530 • Fax: 1-866-781-8999

I. REFERRAL DETAILS

☐ The applicant or lawfully authorized substitute decision maker has consented to this referral.

Date: _____

Name: _____

Agency: _____

Relationship: _____

Telephone: _____

Email: _____

Fax: _____

Referral to Audiology:

FAX: 1-855-259-8152

E-MAIL: audiology@chs.ca

☐ Hearing Test/Hearing Aids

☐ Tinnitus/Hyperacusis

☐ Aural Rehabilitation

☐ Speech Language Pathology

☐ Other: _____

Referral to Counselling:

FAX: 1-866-781-8999

E-MAIL: connectmentalhealth@chs.ca • generalsupportservices@chs.ca • hearingcarecounselling@chs.ca

☐ CONNECT Mental Health

☐ General Support Services

☒ Hearing Care Counselling

☐ Settlement Program for Newcomers

Referral for Employment:

FAX: 1-855-259-8152

E-MAIL: employmentservices@chs.ca

☐ Job Seeker

☐ Workplace Assessment

☐ Other: _____

Referral for Educational:

FAX: 1-855-259-7809

E-MAIL: literacytraining@chs.ca

☐ Literacy and Basic Skills

☐ ASL Education (Sign Language Services)

☐ Language Instruction for Newcomers (LINC)

Referral for Deafblind Services:

FAX: 1-833-842-4255

E-MAIL: deafblindservices@chs.ca

II. CLIENT DEMOGRAPHICS

Client Name: _____

Date of Birth: _____

Address: _____

City: _____ Postal Code: _____

Telephone Number: _____

☐ TTY

☐ Voice

☐ Landline ☐ Mobile

☐ VRS ☐ Text

Email Address: _____

Preferred Language: ☐ English ☐ French

☐ Other: _____

OHIP: _____

Version code: _____

Has client been to CHS before? ☐ Yes

☐ No

Which location: _____

Which program? _____

When? _____

Counsellor's name? _____

III. HEARING HEALTH:

Hearing Status:

☐ Deaf

☐ Deafened

☐ Oral Deaf

☐ Deafblind

☐ Hard of Hearing

☐ Hearing

Communication preference:

☐ Interpreter

☐ Deaf interpreter

☐ Voice

☐ Note taker

☐ Transcription

Contact preference:

☐ Phone

☐ TTY

☐ Text message

☐ E-mail

☐ mail

IV. ALTERNATE CONTACT:

Name: _____

Relationship to Client: _____

Phone number: _____

☐ Mobile ☐ Landline ☐ Text ☐ TTY

Email Address: _____

V. REASON FOR REFERRAL:

Presenting concerns or services requested:

Additional Information - please note or attach information that may be helpful in providing service (eg. diagnosis, audiogram, disabilities, counselling history, technical devices used, medications)