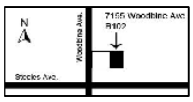
CLEARTONE HEARING CENTRE

Woodbine Medical Centre
7155 Woodbine Ave., Lower Level
Markham, Ontario L3R 1A3
Tel: 416-628-4004 Fax: 416-628-4006
Web: www.cleartonehearing.ca



Cleartone Cancer Care Program

REFERRING DOCTOR

Referring Physician: _____ Billing #: _____

Phone: ( ) _____ Fax: ( ) _____

Email (Optional) _____

PATIENT DEMOGRPAHIC

Name: First Name _____ Last Name _____

OHIP#: _____ Version Code _____

DOB: MM DD YYYY _____

Gender: ☐ Male ☐ Female

Contact Phone # ( ) _____

RELEVANT MEDICAL INFORMATION AND HISTORY

Cancer Type: _____

Date of Diagnosis MM DD YYYY _____

Treatment History: ☐ Radiotherapy ☐ Chemotherapy

☐ Others _____

☐ Pending _____

EAR AND/OR AUDIOLOGICAL CONCERNS

☐ Hearing Loss	☐ Right	☐ Left
☐ Tinnitus	☐ Right	☐ Left
☐ Eustachian Tube Dysfunction	☐ Right	☐ Left
☐ Otitis Media	☐ Right	☐ Left
☐ Ear Drainage	☐ Right	☐ Left
☐ Vertigo		

Others _____

Hearing Aid User? ☐ Yes ☐ Right ☐ Left ☐ No

Hearing Test ☐ Baseline ☐ Repeat after each treatment

COMMUNICATIONS WITH PATIENT'S HEALTHCARE PROVIDER(S)

Is patient currently under the care of an oncologist? ☐ Yes ☐ No

If yes, name of the oncologist: Dr. _____

Is patient currently under the care of an otolaryngologist? ☐ Yes ☐ No

If yes, name of the otolaryngologist: Dr. _____

If no, would you like us to recommend an otolaryngologist? ☐ Yes ☐ No

Any other healthcare provider(s) and/or specialist(s) whom we should send a copy of the patient's records to?

If yes, please specify: _____

_____ _____

Signature Date