SOUTH OAKVILLE
HEARING
& audiology clinic

Client Name: _____ Date: ___/___/_____
DD MM YYYY

REASON FOR REFERRAL

- ○ **Hearing Assessment**
  Adult or Pediatric (0-18)
- ○ **Custom Noise Protection / Swim Plugs**
- ○ **Hearing Aid Consult**
- ○ **Tinnitus Consult**
- ○ **Other**

COMMENTS:

Signed by: Dr. _____ _____
PLEASE PRINT SIGNATURE HERE

○ Send report to referring physician

Gaby Lesniak
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Audiologist & Owner

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