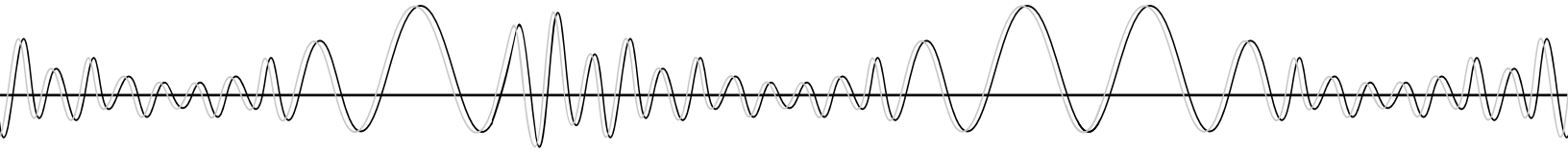
PATIENT REFERRAL

The Hearing & Dizziness CLINIC



Patient Info

Patient Name: _____ _____
First Name Last Name

Phone Number: _____ Date of Birth: _____
DD/MM/YYYY

Reason for Referral

Hearing Loss ☐	Tinnitus ☐	Dizziness ☐

Referral Provider Info

Healthcare Provider Name: _____ _____
First Name Last Name

Address: _____

Phone Number: _____ Fax: _____

Our Clinics

285 Sandwich St. S, **Amherstburg, ON**	35 Victoria Ave, **Essex, ON**	1468 Front Rd, **LaSalle, ON**	1311 Ouellette Ave, **Windsor, ON**

Phone	**Fax**	**Email**
(519) 961-9285	(519) 961-9414	referral@youhear.ca