Referral Form – The Care Clinic at Perley Health
Fax #: 613-526-7126

Client's Personal Information

First name	Last name	Date of birth (dd/mm/yyyy)	Primary phone #
Email			
Address			

Substitute Decision-Maker (if applicable)

First name	Last name	Relationship to client	Primary phone #

Reason for Referral

Audiology: ☐ Hearing assessment (children/adults) ☐ Infant hearing screening (0-6 months) ☐ Hearing aid evaluation/follow-up ☐ Hearing sensitivity ☐ Tinnitus ☐ Auditory Processing Disorder ☐ Earwax/cerumen removal ☐ Other:	**Physiotherapy:** ☐ Rehabilitation ☐ Pain management ☐ Vestibular therapy ☐ Mobility aid assessment - walker ☐ Concussion management ☐ TMJ dysfunction/headache management ☐ WSIB ☐ MVA ☐ Other:
Speech Therapy: ☐ Stuttering assessment/treatment ☐ Cluttering assessment/treatment ☐ Speech sound articulation assessment/treatment ☐ Other:	**Registered Massage Therapy:** ☐ Massage therapy assessment and treatment
Additional Notes:	

Referring Healthcare Provider

First name	Last name	Phone #