
# Markham Hearing Centre

Box Grove Medical Arts Centre
110 Copper Creek Drive, Suite 105
Markham, Ontario L6B 0P9
Ph: **(905) 471-4479** Fax: (905) 472-5436
info@markhamhearing.ca

Date: _____

Patient Name: _____

Date of Birth: _____

Appointment Date / Time: _____

Referring Physician & Billing No. _____

**REASON FOR REFERRAL:**

- ☐ **School Difficulties**
- ☐ **Otitis Media**
- ☐ **Speech / Language Delay**
- ☐ **Vertigo / Tinnitus**
- ☐ **Possible Hearing Loss**
- ☐ **Hearing Aid Problem**
- ☐ **Hearing Aid Assessment**
- ☐ **Other**

Remarks: _____

☐ **Book ENT referral if required**

Physician Signature: _____

☐ Check here if more referral pads are needed