HEARING
LISTENING
TINNITUS
HYPERACUSIS
SOUND id·EARS
CLINIC

CHILD PERSONAL INFORMATION

For Sound idEARS Hearing & Listening Clinic. Vancouver Tinnitus & Hyperacusis Clinic. The information provided is true and accurate. Further, I hereby consent to the assessment and/or treatment to be conducted by Sound idEARS' staff, and to be contacted via mail, phone, and/or email as provided below.

Prefix _____/_____ Last Name _____

Given Name(s) _____ Preferred Name _____

Address _____

City _____ Prov _____ Postal Code _____

Birthdate yyyy _____ mm _____ dd _____ Age _____

School _____ Grade _____

Family Physician (Full Name) _____ Phone _____

Pediatrician (Full Name) _____ Phone _____

Referred by _____

Parent/Guardian _____ Occupation _____

Email _____ Phone _____ Consent ☐

Parent/Guardian _____ Occupation _____

Email _____ Phone _____ Consent ☐

ALL PATIENTS, PLEASE COMPLETE THIS RELEASE OF MEDICAL INFORMATION:

I hereby authorize Sound idEARS Hearing & Listening Clinic, Vancouver Tinnitus & Hyperacusis Clinic to release any and all medical information to the following individuals or organizations:

☐ Sound idEARS is frequently involved in collaborative research projects with other institutes in Canada & the US. I consent to my data being used for research purposes. All personal and identifying data will be kept confidential

☐ Release to Family Physician listed above

☐ Release to referring individual or organization Fax/Email: _____.

☐ Also release to _____ Fax/Email: _____

☐ I do not wish to have my medical information release to any other entity. I understand that any referring individual or organization may still be contacted to indicate that we have completes the referral, but that you have indicated that the information not be released.

Parent/Guardian Signature _____ Date _____

For Office Use
NOH / HLS / PRE / PLU / CAPD / TIN / QUO / MIS / INACT

☐ EW DATA CHECKED

Follow-up _____

☐ REFERRAL CHECKED

v2017.0