



# 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.

Mr/Ms/\_\_\_\_\_ 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
- Also release to \_\_\_\_\_
- 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

Follow-up \_\_\_\_\_

EW DATA CHECKED

REFERRAL CHECKED