

## Eligibility Form for Infant Hearing Program

*One of the criteria below must be indicated for IHP services  
If IHP eligibility is not met, review the Communication Checklist at [toronto.ca/earlyabilities](http://toronto.ca/earlyabilities)  
Physician can be consulted for resources outside of IHP*

<b>CLIENT INFORMATION</b>		Referral Date: _____ / _____ / _____ yyyy / mmm / dd
Child's Name: _____ Last Name / First Name		DOB: _____ / _____ / _____ yyyy / mmm / dd
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous Genitalia <input type="checkbox"/> Unknown	Gestational Age: (# weeks pregnant)	
Home Address:		Corrected Age: current age - # weeks premature (using 37 weeks as full term) = corrected age
Day time number:	Evening number:	Email address:
Parent/Legal Guardian Name(s):		Service Language (if not English):

### INFANT UNDER 2 MONTHS CORRECTED AGE

- Missed Universal Newborn Hearing Screening (UNHS)
- Passed UNHS and a parent or professional is concerned about *change* in hearing status

### INFANT 2 – 24 MONTHS CORRECTED AGE

- Post-natal infection associated with a permanent hearing loss (PHL) including meningitis, viral encephalitis or labyrinthitis. Date and Name of Diagnosis: \_\_\_\_\_

#### Diagnosis of one or more of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Alport Syndrome                                       | <input type="checkbox"/> Pendred/Enlarged Vestibular Aqueduct (EVA) |
| <input type="checkbox"/> Branchio-Oto-Renal (BOR)/Branchio-otic (BO)           | <input type="checkbox"/> Proven cCMV                                |
| <input type="checkbox"/> CHARGE Syndrome                                       | <input type="checkbox"/> Stickler Syndrome                          |
| <input type="checkbox"/> Craniofacial anomaly (cleft palate, atresia/microtia) | <input type="checkbox"/> TORCHES                                    |
| <input type="checkbox"/> Crouzon Syndrome                                      | <input type="checkbox"/> Treacher-Collins Syndrome                  |
| <input type="checkbox"/> Down Syndrome   | <input type="checkbox"/> Usher Syndrome                             |
| <input type="checkbox"/> Goldenhar (OAVS) Syndrome                             | <input type="checkbox"/> Waardenburg Syndrome                       |
| <input type="checkbox"/> Neurofibromatosis II (NF2)                            |   |
- Significant head trauma associated with loss of consciousness or skull fracture
  - Extracorporeal Membrane Oxygenation (ECMO)

### CHILD 2–6 YEARS OF AGE

- PHL Diagnosis (Please include summary of hearing loss and latest diagnostic reports): \_\_\_\_\_

Name of Referring Source: \_\_\_\_\_ Phone: \_\_\_\_\_

### CONSENT

- Are Parents/Legal Guardians aware of and consenting to this referral?  Yes  No
- Any special custody arrangements? CAS and/or adoptive arrangements?  Yes  No

Updated March 2020

Personal health information contained on this form is collected in accordance with the Personal Health Information Protection Act (2004) for the purposes of providing the Infant Hearing Program. The information captured on this form to be entered into a secure database administered by the Ministry of Children and Youth Services. Access to your baby's record is protected by Toronto Public Health. If you have any questions regarding your consent or our services please call 416-338-8255.