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| **InHealth Logo (Smaller).jpg** | **C:\Documents and Settings\Darren.Bourne\Desktop\NHS Logo.png** |

 **Community Paediatric Audiology**

**REFERRAL FORM FOR CHILDREN WITH HEARING PROBLEMS**

**ENT HOSPITAL AUDIOLOGY COMMUNITY AUDIOLOGY**

**THIS REFERRAL WILL BE DIRECTED TO THE MOST APPROPRIATE DEPARTMENT**

**All referrals sent by email must be sent from an nhs.net account to an nhs.net account, failure to comply with this requirement may result in a fine from the Information Commissioner.**

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| **PATIENT DETAILS** | **REFERRER DETAILS: If the referrer is NOT the GP please ensure GP details are given below No GP detail could lead to the referral being returned.** GP: [ ]  Health Visitor: [ ]  School nurse: [ ] Speech Therapist: [ ]  Paediatrician: [ ]  Other: [ ]  Community Health Nurse: [ ]  |
| NHS Number |  | Name |  |
| Forename |  | GMC/HPC/NMC No |  |
| Surname |  | Address |  |
| Address |  |  |  |
| Date of Birth |  | Referring CCG Code |  |
| Telephone (Home) |  | Referring Practice Code |  |
| Telephone (Work) |  | Telephone No. (for urgent clinical findings) |  |
| Telephone (Mobile) |  | Fax No. |  |
| E-mail Address |  | NHS.net mail only |  |
| Gender | Male [ ]  Female [ ]  | Are parents happy to receive text appt reminders? Yes [ ]  No [ ]  |
| **Newborn hearing screen result:****Ethnicity:****School attended:** | **Please give GP details if not the referrer:****Safeguarding Concerns** [ ] **On Child Protection Plan** [ ] **Looked After Child** [ ] **Name of Social Worker (if applicable):**  |  |
| Please indicate which clinic location is preferred (we cannot guarantee to meet these requests but will do our best)**Pickles Coppice Millbrook**: [ ]  **Weston Clinic**: [ ]  **Ashurst Hospital**: [ ]  **Please indicate your opinion of the urgency of this referral: URGENT**[ ]  **SOON** [ ]  **ROUTINE** [ ] ---------------------------------------------------------------------------------------------------------------------------------------------------------Reason for Referral: Please tick all that apply

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| Failed Hearing Screen [ ]  | Behaviour Problems [ ]  |
| Parental Concerns about hearing [ ]  | Secretory Otitis [ ]  |
| Speech Delay [ ]  | Educational Concerns [ ]  |
| Recurrent Ear Infections [ ]  |  |

**Further details if appropriate: Past Medical History:****Family History of Permanent Childhood Hearing Impairment**:**Additional Information:**Date of referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please send this referral form to:**InHealth Paediatric Audiology Team, InHealth Patient Referral Centre, Sandbrook House, Sandbrook Way, Rochdale, OL11 1RY. Email: ih.paediatricaudiology@nhs.net Tel: 0333 202 1065 Fax: 0333 009 6973**  | **M** |

**Office Use Only: Community Audiology:** [ ]   **UHS** **Audiology** [ ]  **UHS ENT** [ ]