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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     |  |  | | --- | --- | | 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**