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**Community Paediatric Audiology**

**REFERRAL FORM FOR CHILDREN WITH HEARING PROBLEMS**

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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 nursing team:  Speech Therapist:  Paediatrician:  Community Health Nurse:  Other:  Please specify Click or tap here to enter text. | |
| NHS Number |  | Referrer Name |  |
| Forename |  | GMC/HPC/NMC No |  |
| Surname |  | Referrer Address |  |
| Address |  |  |  |
| Postcode |  |
| Date of Birth |  | Referring CCG Code |  |
| Telephone number | Home:  Mobile:  Work: | Referring Practice Code |  |
| Telephone No.  (for urgent clinical findings) |  |
| Email address |  | Email for correspondence (NHS.net email preferred) |  |
| Gender | Male  Female | Is an interpreter required? | Yes  No  Language: |
| Are parents happy to receive appointment letters and clinical reports by email? Yes  No  Are parents happy to receive text appt reminders? Yes  No  **Newborn hearing screen result:**  **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**:  ---------------------------------------------------------------------------------------------------------------------------------------------------------  Reason for Referral: Please tick all that apply     |  |  |  | | --- | --- | --- | | Failed Hearing Screen | Recurrent Ear Infections | Behaviour Concerns | | Parental Concerns about hearing | Otitis media with effusion | Educational Concerns | | Speech Delay |  |  |   **Further details if appropriate:**  **Any Family History of Permanent Childhood Hearing Impairment (**please note that a family history of glue ear does not require a referral, unless there are **also** concerns about a child’s hearing**)**:  **Additional Information:**  Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Please send this referral form to:  **Email:** [uhs.tier2paedaudiology@nhs.net](mailto:uhs.tier2paedaudiology@nhs.net)  **Postal address:** Community Paediatric Audiology Team, Mary Seacole Wing Level A, Royal South Hants Hospital, Brintons Terrace, Southampton SO15 5NU. **Tel: 023 8054 0188** (8.30am-4.30pm) | | | |