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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

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| 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 **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) |