ADULT HEARING REFERRAL FORM

Patients aged 55 years and over

This service is delivered by InHealth on behalf of the NHS in East Sussex

PATIENT		**REFERRER**	
NHS Number		Name	
Forename		GMC/HPC/NMC No	
Surname		Address	
Address			
Date of Birth		Referring PCT 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 ☐	Eligible for and does require NHS funded transport? Yes ☐	
Home Visit Required ☐		If interpreter required, language:	Ethnicity:

PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS

Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and results.

Date of referral _____

DO NOT REFER THE FOLLOWING: Patients with ear infections, asymmetry, perforations of the tympanic membranes, sudden loss of hearing.

Please can you ensure that the patient's ears are clear of wax before their appointment.

Has the patient previously been fitted with a hearing aid?	Yes ☐ No ☐
Date of last hearing assessment	_ _ / _ _ / _ _ _ _
If previous hearing assessment in last four months, please attach results.	

Please post, fax or email this referral form to:

InHealth Patient Referral Centre, Sandbrook House, Sandbrook Way, Rochdale, Lancashire OL11 1RY

Tel: 0333 202 0298 **Fax: 0333 200 1163** **Email: INL.inhealthreferrals@nhs.net**

March 2015

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.