AUDIOLOGY REFERRAL FORM

NB: we are unable to accept referrals for patients under 18 years of age

NB: At busy periods there is limited car parking on site

PATIENT		**REFERRER**	
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 ☐	Eligible for and does require NHS funded transport? **(car transport only)** Yes ☐	
Physical/Communication difficulties (specify if any):		Wheelchair user? Yes ☐	
If interpreter required, language:		The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch.	
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

Please can you ensure that the patients ears are clear of wax if possible 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 e-mail this form to the InHealth Patient Referral Centre:
Sandbrook House, Sandbrook Way, Rochdale OL11 1RY
Tel: 0333 202 0297 Fax: 0333 200 1163 E-mail: INL.inhealthreferrals@nhs.net