ADULT HEARING SERVICE REFERRAL FORM

Patients aged 55 years and over

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 ☐	If interpreter required, language:	

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: 0845 437 0347 Fax: 0845 437 0348 Email: INL.inhealthreferrals@nhs.net **version: Dec 2012**