|  |  |
| --- | --- |
| **InHealth Logo (Smaller).jpg** | **C:\Documents and Settings\Darren.Bourne\Desktop\NHS Logo.png** |

**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. If you have performed a hear checker test on the patient, please include the results below.  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?  Date of last hearing assessment  If previous hearing assessment in last four months, please attach results. | | | | Yes No  **\_ \_ / \_ \_/ \_ \_ \_ \_** |
| 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** | | | | | **Version: August 2012**  **www.inhealthgroup.com** |