City and Hackney
Clinical Commissioning Group

AUDIOLOGY REFERRAL FORM

Please use this form for existing hearing aid users repairs and follow-up and new patients over 18 years and over 30 years who have not been fitted previously

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		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: ~[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, Lancashire OL11 1RY
Tel: 0333 202 0297 Fax: 0333 200 1163 E-mail: london.prc@nhs.net