|  |  |
| --- | --- |
|  | [Description: Image result for city and hackney ccg](http://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwipm_Sq__vVAhXFJlAKHRomBuQQjRwIBw&url=http%3A%2F%2Fwww.cityandhackneyccg.nhs.uk%2FDefault.aspx.LocID-01603300v008.Lang-EN.emID-1353.cal-yes.EventID-31266.htm&psig=AFQjCNFjrqQAeADT2vT-z8g19cYpgXbRlg&ust=1504080675213260) |

**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?  Date of last hearing assessment  If previous hearing assessment in last four months, please attach results. | | | | Yes No  **/** **/** |
| **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** | | | | **www.inhealthgroup.com**  **Version: August 2017** |