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**Parent/Guardian Referral - Community Paediatric Audiology**

**REFERRAL FORM FOR CHILDREN WITH HEARING PROBLEMS**

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| **CHILD DETAILS** | | **PARENT/GUARDIAN DETAILS:** | |
| NHS Number (if known) |  | Parent/guardian name |  |
| Forename(s) |  | Relation to child |  |
| Surname |  | Address (if different from child) |  |
| Address |  |
| Postcode |  | Parent/Guardian Telephone (Mobile) | Mobile:  Home:  Work: |
| Date of Birth |  |
| Gender | Male  Female |
| **Newborn hearing screen result (see red book Pass/Fail):**  **Nursery/Pre-School/School attended:** | | E-mail Address |  |
| Is an interpreter required? | Yes  No  Language: |
| Are you happy to receive appointment letters and clinical reports by email? Yes  No | |
| **GP Name:**  **Dr  GP Surgery: Wistaria and Milford Surgeries GP Address:**  **Wistaria Court**  **18 Avenue Road**  **Lymington**  **SO41 9GJ** | |
| Are you happy to receive text appt reminders? Yes  No | |
| **Is the child currently under the care of social services?**  Yes  No  **Name of Social Worker (if applicable):**  **Social Worker contact number:**  **Social Worker email:** | |
| Please indicate which clinic location is preferred (we cannot guarantee to meet these requests but will do our best)  **Pickles Coppice Millbrook**:  **Weston Clinic**:  **Ashurst Hospital**:  ---------------------------------------------------------------------------------------------------------------------------------------------------------  **Reason for Referral: (Please provide a summary of your concerns)**  **Medical History:**  **Family History of Permanent Childhood Hearing Impairment (Loss)**:  **Additional Information:**  Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Please send this referral form to:  **Email:** [uhs.tier2paedaudiology@nhs.net](mailto:uhs.tier2paedaudiology@nhs.net) **Tel: 023 8054 0188** (8.30am-4.30pm) | | | |