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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 SurgeriesGP 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 **Tel: 023 8054 0188** (8.30am-4.30pm) |