InHealth

NHS Peterborough

# AUDIOLOGY REQUEST FORM

**PLEASE NOTE - WE ARE UNABLE TO ACCEPT REFERRALS FOR PATIENTS UNDER 18 YEARS OF AGE**

## Patient ID

NHS number: ____________________
First name: ____________________
Surname: ____________________
Address: ____________________
____________________
Post code: ____________________
Date of birth: ____________________
Telephone: ____________________ (home)
____________________ (work)
____________________ (mobile)
Email: ____________________
Gender: Male ☐ Female ☐
Is the patient registered disabled: Yes ☐ No ☐
If Interpreter required, language? ____________________
For monitoring purposes please state ethnicity of patient:
____________________

## Referring Clinician

Name: ____________________
Qualifications: ____________________
GMC/HPC no: ____________________
Referring PCT Code: ____________________
Referring Practice Code: ____________________
Address: ____________________
____________________
____________________
Post code: ____________________
Urgent telephone*: ____________________
Fax*: ____________________
*for clinical enquiries use only*
NHS mail: ____________________
Clinical speciality: ____________________

## Relevant Past Medical History (include previous and current treatment/medication where relevant)

| | |
|---|---|
| **Are the ears free from occluding wax?**<br>**If the answer is no then the patient should not be referred until a wax treatment has been completed** | Yes ☐ No ☐ |
| Has the patient previously been fitted with a hearing aid? | Yes ☐ No ☐ |

***If you have answered "yes" to any of the questions above please ensure that you include any relevant information in the relevant past medical history section.***

Referrer's Signature ............................................................ Date of request

Please send or fax this form to the InHealth Audiology Referral Centre:
Beechwood Hall, Kingsmead Road, High Wycombe, Buckinghamshire HP11 1JL
Tel: 0845 602 6918 Fax: 0845 602 6919 E-mail: audiologycustomercare@inhealthgroup.com

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