SOUTHAMPTON CITY/WEST HAMPSHIRE AUDIOLOGY REFERRAL FORM

Please note – we are unable to accept referrals for patients under 16 years of age

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)		NHS.net mail only	
E-mail Address			
Gender	Male ☐ Female ☐	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:			
Ethnicity			

Does the patient have any of the following? (Please choose an option before proceeding with the referral):

Programmable Ventriculo-Peritoneal (PVP) shunt Yes ☐ No ☐

Eye shunt Yes ☐ No ☐

Pacemaker Yes ☐ No ☐

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.	