CHILDREN’S AUDIOLOGY REFERRAL FORM

**Please send this to:**

**The Children & Young People’s Audiology Centre, St Thomas’ Hospital, South Wing, 2nd Floor, Westminster Bridge Road, London, SE1 7EH**

**Tel: 020 3049 8560 Email: gst-tr.CYPACReferrals@nhs.net**

**Referrer**

Name: Date:

Designation:

Address:

Phone number and/or email:

Please indicate patient’s GP’s Borough

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| --- | --- | --- | --- | --- | --- | --- |
| Southwark | Lambeth | Lewisham | Bromley | Greenwich | Bexley | OTHER  Specify: |

**Child’s details**

DOB:

Surname/family name:

First names:

Address:

Post Code:

Telephone Numbers:

NHS Number:

GP name and address (including postcode):

Ethnicity:

Gender: Male Female Prefer not to say

**Interpreter**

Language required:

**Social services**

Child Protection Plan in place  Social worker details

Looked after child  Name:

Complex medical needs  Borough:

**Reason for referral:**

Significant parental concern (hearing)  Details:

Professional concern (hearing)

Speech and language delay

Social communication difficulties

Child verbal

Child non-verbal

Failed previous hearing test (give details)

Other (give details)

**Specific audiology risk factors:**

Bacterial meningitis  Details:

Jaundice at exchange transfusion level

Congenital CMV

Cleft palate

Trisomy 21

Microtia and atresia

Ototoxic medication (specify)

Significant past medical history / Other relevant info

*Inpatient stays, other diagnoses, not normal neonatal period*

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| --- | --- | --- |
| **PURE TONE SWEEP**  (25dBHL) | 500Hz  1000Hz  2000Hz  4000Hz | **Date:**  .......... .......... .......... ..........  .......... ..........  .......... .......... |

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