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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Southwark | Lambeth | Lewisham | Bromley | Greenwich | Bexley | OTHERSpecify: |

**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*

|  |  |  |
| --- | --- | --- |
| **PURE TONE SWEEP** (25dBHL) | 500Hz1000Hz2000Hz4000Hz | **Date:**.......... .......... .......... .................... .................... ..........  |

**For more information on our services visit** [**evelinalondon.nhs.uk/audiology**](http://evelinalondon.nhs.uk/audiology)