REFERRAL FOR AUDIOLOGY ASSESSMENT AT CHARING CROSS HOSPITAL OR PARKVIEW CENTRE FROM HEALTH VISITORS/SPEECH & LANGUAGE THERAPISTS

Referral Details	
Date of Referral	
Referrer's Name & Designation	
Referrer's Address (base)	
Referrer's Contact No. & Email	

GP name:	Health Visitor Name:
GP Address:	Health Visitor Base:
Telephone no.	Telephone no.

Patients Details		
Surname:	NHS Number:	
First name:	Hospital Number:	
Sex:	D.O.B	
Address:	Looked After Child	
	Looked After Child Details	
Telephone No:	School:	

History			
Reason for Referral	Parental hearing concern ☐ Professional hearing concern ☐ Speech and language delay ☐ Social communication difficulties Child verbal ☐ Child non-verbal ☐ Failed previous hearing test (give details) ☐ Other (give details) ☐	Details:	
Pregnancy/Delivery & Postnatal period information			
NHSP Screen	Yes ☐	No ☐	Don't know ☐
Interpreter required? *Specify language if required*			
General Development			
Other Information *Inpatient stays, other diagnoses, health professionals involved, neuroatypical, unlikely to tolerate clinicians touching ears*			

Pease return to childrens.hearing@nhs.net or by post to Children's Hearing, 2nd Floor North Wing, Charing Cross Hospital, Fulham Palace Road, London W6 8RF.