REFERRAL FOR AUDIOLOGY ASSESSMENT AT ST MARYS HOSPITAL OR WOODFIELD ROAD FROM HEALTH VISITORS/SPEECH & LANGUAGE THERAPISTS

Central London Community Healthcare

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 smpaediatric.audiology@nhs.net or by post to Paediatric Audiology, 6th Floor, QEQM building, St Marys Hospital. Praed Street. W2 1NY.