REFERRAL FOR AUDIOLOGY ASSESSMENT AT CHARING CROSS HOSPITAL OR PARKVIEW CENTRE FROM SCHOOL NURSES

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

GP Details	
GP Name & Address	

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			
Parental Concerns			
School Concerns			
NHSP Screen	Yes	No	Don't know
Language Development			
Interpreter required? *Specify language if required*			
General Development *Other diagnoses, health professionals involved, neuroatypical, unlikely to tolerate clinicians touching ears*			

Hearing Test				
Date of Test:				
No of Sweep Test:				
	Frequency (Hz)			
	500	**1000**	**2000**	**4000**
Right Ear				
Left Ear				

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.