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| **Parent/Guardian referral****Community Paediatric Audiology**Referral for children with hearing concerns**Please complete all sections** | Please send this referral form to: |
| **Email:** paedaudiologyreferrals@uhs.nhs.uk |
| **Postal address:** AudiologyLevel A, Royal South Hants Hospital, Brintons Terrace, Southampton SO14 0YG.**Tel: 023 8120 2997**  |

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| **PATIENT DETAILS** |
| NHS Number |  |
| Forename |  |
| Surname |  |
| Address |  |
| Postcode |  |
| Date of Birth |  |
| Gender | Male [ ]  Female [ ]  |
|
| Are you happy to receive text message reminders Yes [ ]  No [ ]  |
| **GP surgery Name and address:** |
| **Please indicate your preferred clinic location**: We cannot guarantee to meet these requests but will do our best. Pickles Coppice Millbrook: [ ]  Weston Lane centre for healthy living: [ ]  Ashurst child and family centre:[ ]   |



|  |  |
| --- | --- |
| Name |  |
| Relationship to child |  |
| Address (if different to child) |  |
| Telephone Number | Home:Mobile: |
| Email address |  |
| Is an interpreter required? Please state language if yes | Yes [ ]  No [ ]  Language: |
| Newborn hearing screen result (see red book)Pass [ ]  Fail [ ]  Nursery/Pre-School/School attended: |
| **Is the child currently under the care of social services?** Yes [ ]  No [ ] **Name of Social Worker (if applicable):****Social Worker contact number:****Social Worker email:** |

**PARENT/GUARDIAN DETAILS**

**Reason for Referral**:  **(Please provide a summary of your concerns)**

**Medical History:**

**Family History of Permanent Childhood Hearing Impairment (Loss)**:

Date of referral: \_\_\_\_\_\_\_\_\_\_\_ Signature of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_