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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](mailto:paedaudiologyreferrals@uhs.nhs.uk) |
| **Postal address:**  Audiology  Level 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_