Referral Form to Adult Audiology Service for Patients with Learning Disabilities

Date:

Referrer: Title:

**Patient Details:**

Name:

D.O.B:

Address:

Telephone Number:

NHS Number:

GP Name:

GP Address:

**Patient Details**

**Exclusion**

**Reason for Referral:**

**Communication / Ability to Respond:**



**Referral Criteria** [please tick]

|  |  |  |  |
| --- | --- | --- | --- |
| Aged 19 years or over |  | Symmetrical hearing loss |  |

**Exclusion Criteria** [please tick]

|  |  |  |  |
| --- | --- | --- | --- |
| No wax |  | No perforation |  |
| No otalgia [pain] |  | No tinnitus |  |
| No vertigo |  | No ear surgery |  |
| No ear discharge |  | No sudden onset hearing loss |  |

**Previous involvement from Audiology / Hearing aid use:**

**Please give any details of any other healthcare professional or agencies that this patient is currently under the care of:**

**Patient Likes, Dislikes, Anxieties & Fears (any anxieties about headphones, clinics or clinicians):**