**Referral for Children’s Audiology Assessment (0-19 years)**

Please note: if family are in a period of isolation due to covid-19 symptoms please only refer once the isolation period has ended.

**Patient Details:**

Click here to enter a date.

|  |  |  |
| --- | --- | --- |
| **Surname** | Click or tap here to enter text. | Male |
| **Forename** | Click or tap here to enter text. | Female |

|  |  |
| --- | --- |
| **Parents / Guardian** | Click or tap here to enter text. |
| **Address Line 1** | Click or tap here to enter text. |
| **Address Line 2** | Click or tap here to enter text. |
| **Address Line 3** | Click or tap here to enter text. |
| **Post Code** | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **NHS No** | Click or tap here to enter text. | **D.O.B** | Click here to enter a date. |
| **Home Phone no** | Click or tap here to enter text. | **Mobile** | Click or tap here to enter text. |
| **Parents/Guardian happy to be contacted by text and/or voicemail on answerphone** Yes No | | | |

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| --- | --- | --- |
| **Languages used** | English | Other: Click or tap here to enter text. |
| **If Interpreter required, state language required:** Click or tap here to enter text. | | |

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| --- | --- | --- | --- | --- |
| **Other professionals seen** | Paediatrics  Physio | ENT  SALT | Child Dev  Social Worker | Other: Click or tap here to enter text. |

|  |  |
| --- | --- |
| **GP Surgery Name** | Click or tap here to enter text. |
| **School / Nursery attending:** | Click or tap here to enter text. |
| **Preferred method of contact:** | Post  Phone |

**Safeguarding:**

Please tick as appropriate

|  |  |  |  |
| --- | --- | --- | --- |
| No concerns | Child in Need | Subject to a child protection plan | Child in care |
| **Social care contact:**  As required | Click or tap here to enter text. | | | |

**Referrer’s Details (If GP, only *name* required if *Surgery Name* complete):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Profession** | GP | ENT | Health Visitor | SALT: | Paediatrician | Other: Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Name** | Click or tap here to enter text. | |
| **Address Line 1** | Click or tap here to enter text. | |
| **Address Line 2** | Click or tap here to enter text. | |
| **Address Line 3** | Click or tap here to enter text. | |
| **Post Code** | Click or tap here to enter text. | |
| **Telephone** | Click or tap here to enter text. | Email for reports: Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Reason for referral** (If left blank, your referral will be rejected): Please also include any information that may be relevant to management **please specify what the hearing concerns are**.  Click or tap here to enter text. | |
| **History of:** |
| **Frequent ear infections (3 or more within 6 months)** | Yes No |
| **Abnormality of the head, face, neck, including cleft palate** | Yes No |
| **Chromosomal abnormality, syndrome, neuro-developmental or degenerative disorder** | Yes No |
| **Global Development delay** | Yes No |
| **Hypoxic Ischaemic Encephalopathy (Brain damage due to lack of blood supply)** | Yes No |
| **Severely Sight impaired** | Yes No |
| **Diagnosis of other health condition (Such as autism / ADHD)** | Yes No |
| **Significant head injury (Such as a skull fracture)** | Yes No |
| **Treatment of Bacterial meningitis / meningococcal septicaemia** | Yes No |
| **If any boxes are ticked yes, please add details below:** (If left blank, your referral will be rejected)  Click or tap here to enter text. | |

Please ensure this child meets the referral criteria overleaf

## Children’s Audiology Referral Criteria.

## Author: Jennifer Western (Deputy Team Leader and Lead Audiologist)

## Reviewed by: Helen Hindle (Team Leader)

## Date: July 2020 For Review: July 2021

## Contact Details of Author:

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## Summary:

This document is intended as guidance for health care professionals referring into Wigan Community Children’s Audiology service.

Please note that our referral criteria has been set to reduce the number of children that are often seen with satisfactory hearing, or that are needing to be seen by a different specialist.

|  |  |
| --- | --- |
| **Acceptance criteria:** | **Rejection Criteria:** |
| Parental/ nursery/health care professional/ school concerns about hearing | Family history of grommets/glue ear without parental concern |
| Previously failed hearing assessment | Family history of permanent hearing loss without parental concern |
| Glue ear or “ear infections” with hearing concerns | ENT related symptoms – Mouth breathing, snoring, discharging ears, sore throats, colds, wax without hearing concerns  (These should be referred to ENT where you feel appropriate) |
| Children with speech delay **AND** specific hearing concerns | Vague reasons for referral |
|  | Incomplete or incorrect referral form |
|  | As part of an autism pathway without hearing concerns |