**Whipps Cross University Hospital**

**Paediatric Audiology Service**

**e-mail:** **bhnt.paediatricaudiologywx@nhs.net**

Referral Form

**Paediatric Audiology**

Name of Child:

Address:

Gender: Telephone No.:

DOB: School/Nursery:

NHS No.:

GP:

Name of Referrer: Designation:

Address

of referrer: Date of Referral:

We need as much information as possible in this section. In particular, information about previous hearing screens is substantially useful.

Reasons for referral:

Are risk factors for hearing impairment present? Y / N

Details and risk factor category:

Have parental concerns been expressed about the hearing? Please provide details:

Are the results of the previous hearing results known? e.g., Newborn hearing screening test /school screening test

Are there any other agencies involved with this child? (e.g., Speech Therapy, Children's Centre, ENT, Paediatric Dept., Social Workers)

Do you think this child needs their hearing monitored regularly ongoing? Y / N

Reasons:

Do you consider this appointment URGENT? Y / N

If yes, please give reasons or the referral may be triaged as non-urgent:

Does this child have a diagnosis of Autism Spectrum Disorder?

If yes, please provide evidence of this diagnosis:

Please email this form to bhnt.paediatricaudiologywx@nhs.net or post to:

**Paediatric Audiology (Waltham Forest patients)**

**First Floor**

**Wood Street Health Centre**

**6 Linford Road**

**London**

**E17 3LA**

**Paediatric Audiology (Redbridge patients)**

**Reception 2B**

**Loxford Polyclinic**

**417 Ilford Lane**

**Ilford**

**IG1 2SN**