Whittington Health NHS

PAEDIATRIC AUDIOLOGY

REFERRAL FORM TO BE SENT TO

Patient must be registered with Barnet CCG GP or Enfield CCG GP

Paediatric Audiology & Audiovestibular Medicine, Children's Services (Management)
Edgware Community Hospital
Edgware, HA8 0AD
Tel. 020 – 3316 8080
email: paediatric.audiology@nhs.net

PLEASE NOTE THAT THIS IS A 2ND TIER SERVICE AND ACCEPTS REFERRALS FOR CHILDREN OVER 6 MONTHS OF AGE. REFERRALS FOR CHILDREN <6 MONTHS NEED TO BE SENT TO THE NUFFIELD PAEDIATRIC AUDIOLOGY BARNET CCG PATIENTS AND ST ANNS PAEDIATRIC AUDIOLOGY FOR ENFIELD CCG PATIENTS

PLEASE NOTE THAT ALL SECTIONS WILL NEED TO BE FULLY COMPLETED OR THE REFERRAL WILL BE RETURNED

PATIENT DETAILS (BLOCK CAPITALS)			
First Name		NHS Number	
Surname		D.O.B	
Gender		Interpreter Required	Yes ☐ No ☐
Address		Language Spoken	
Postcode		Telephone Number	
Health Visitor/ School Nurse		Nursery / School	
GUARDIAN DETAILS (BLOCK CAPITALS)			
Name		Relationship to patient	
Address + Postcode	(Only if different from above)	Telephone Number	
Email Address		CONSENT for e-mail correspondence	Yes ☐ No ☐

REFERRER DETAILS (BLOCK CAPITALS) Date of Referral:			
Name		Designation	
Address + Postcode		Email	
Electronic Signature		Telephone number	
GP DETAILS (BLOCK CAPITALS)			
Surgery Name			
Telephone			
Address + Postcode			

Whittington Health NHS

Patient Name		NHS Number	

CHILD PROTECTION			
Does the child have a child protection plan, Looked After or is known to social services?			Yes ☐ No ☐
If Yes, Please give Social Workers details:			
Name			
Telephone			
Address		Postcode	
Foster Carer's Name			

Has this referral been discussed with and agreed by the Parent/Guardian Yes ☐ No ☐

PLEASE ADVISE THE PARENT OF THE IMPORTANCE OF ATTENDING THIS APPOINTMENT

WE OPERATE A PARTIAL BOOKING SERVICE FOR SOME PATIENTS. IF PATIENTS FAIL TO RESPOND TO A PARTIAL BOOKING LETTER, THEY WILL BE DISCHARGED BACK TO THE REFERRER.

Has partial booking been discussed with and agreed by the Parent/Guardian? Yes ☐ No ☐

HEARING		
Are there Parental concerns?	Yes ☐	No ☐
Are there professional concerns at time of assessment?	Yes ☐	No ☐
Did the child pass the neonatal hearing screen at birth?	Yes ☐	No ☐
Did the child pass the School Entry Hearing Screen	Yes ☐	No ☐

REASON FOR REFERRAL	Is this an urgent referral? Y/N – If yes please provide details why

N.B: [If baby in NICU-please enclose neonatal discharge summary]

Does the patient have a PVP shunt? Y/N

OTHER PROFRESSIONALS INVOLVED? (incl. name & email address –or CAF copy– and attach recent reports)	
Paediatrician	
Speech and Language Therapist	
ENT surgeon	
OTHER	

END OF REFERRAL FORM – PLEASE SEND ALL PAGES FOR PROCESSING

PREFERRED CLINIC: Edgware Hospital ☐ OLCHC, N2 8LT ☐ St.Michael's,EN2 0JB ☐ V1April 2020