Whittington Health NHS

PAEDIATRIC AUDIOLOGY

REFERRAL FORM TO BE SENT TO EITHER

Haringey/Out of Borough Resident or

2nd Tier Paediatric Audiology/Audio Vestibular Medicine Service, St Ann's Hospital
St Ann's Road N15 3TH
Tel: 020 3224 4698/4689/4626
email: whh-tr.StAnns-Audiology@nhs.net

Camden/Islington Resident

2nd Tier Paediatric Audiology
Northern Health Centre
580 Holloway Road N7 6LB
Tel: 020 3224 4604
email: whh-tr.childaudiology@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, ROYAL NATIONAL THROAT NOSE AND EAR HOSPITAL (RNTNEH).

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	Male / Female	**Interpreter Required**	**Yes** ☐ **No** ☐
Address		**Language Spoken**	
E-mail address		**CONSENT for e-mail correspondence**	**Yes** ☐ **No** ☐
Postcode		**Telephone Number**	
Health Visitor/ School Nurse		**Nursery / School**	

REFERRER DETAILS (BLOCK CAPITALS) **Date of Referral:**			
Name		**Designation**	
Address + Postcode		**Email**	
		Telephone number	

GP DETAILS (BLOCK CAPITALS)	
Name	
Telephone	
Address	
Postcode	

PLEASE TURN OVER TO COMPLETE FORM

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 ☐

REASON FOR REFERRAL

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