# Paediatric Audiology Department

# For families in Peterborough who are non- drivers, email to: nwangliaft.audiologymail@nhs.net

**For families in Huntingdonshire and Peterborough who are drivers, email to** **nwangliaft.hhpaedsreferrals@nhs.net** **Direct Line: (01480) 416139**

#  PAEDIATRIC AUDIOLOGY SERVICE – REFERRAL FORM

|  |  |
| --- | --- |
| Name in full (Surname, First name): |  |
| Date of Birth: | Date of Referral: |
| Address:  | **NHS Number:**  |
| Telephone Number:  | **Daytime contact number:** |
| Name of GP:  | Able to attend at short notice? |
| Child & Family Nurse:  |  |
| School / Nursery / Playgroup:  |  |

|  |  |  |
| --- | --- | --- |
| Reason(s) for Referral:(Please tick)  | [ ]  Parental Concern [ ]  Educational Concern [ ]  Speech / Language Delay  | [ ]  ENT Symptoms[ ]  Behaviour [ ]  Other (give details):  |
| Observations / Comments:  |
| Newborn Hearing Screening Date: Results:  |
| Previously seen in Paediatric Audiology? Date Seen & Result:  |  |
| Language Development Delayed? |  |
| Referred to Speech Therapy? |  |
| Family History of Permanent Childhood Hearing Loss?Details:  |  |
| Medical History:  | [ ]  Recurrent URTI | [ ]  Nasal Obstruction | [ ]  Allergies: |
|  | [ ]  Discharging Ear | [ ]  Ear Infections | [ ]  Perinatal Problems |
| Social History (any relevant factors): |
| Place of Birth/Date moved into area:  |

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| --- | --- |
| Parental Consent to Referral? Would you like a copy of the appointment letter to assist attendance?  |   |
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**Referred by: Contact Number**