**AQP DIRECT ACCESS HEARING LOSS REFERRAL FORM**

**FOR PATIENTS 55 YEARS AND OVER WITH SUSPECTED OR DIAGNOSED AGE RELATED HEARING LOSS**

**Please complete ALL fields below, incomplete forms will be returned to the referrer**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Details:** | | | | |
| **NHS Number:** | **<NHS number>** | | **Date of Birth:** | **<Date of Birth>** |
| **Surname:** | **<Patient Name>** | | **Title:** | **<Patient Name>** |
| **Forenames:** | **<Patient Name>** | | | |
| **Address:**  **<Patient Address>** | | | | |
| **Postcode:** | | **<Patient Address>** | **Email Address:** | **<Patient Contact Details>** |
| **Preferred Tel No:** | | **<Patient Contact Details>** | **Mobile Tel No:** | **<Patient Contact Details>** |
| **Ethnic Origin** | | **<Ethnicity>** | | |

|  |  |  |
| --- | --- | --- |
| **Referring GP Details:** | | |
| **Name: <GP Name>** | **Registered GP:** | **<GP Name>** |
| **Practice: <Organisation Address>** | | |
| **Tel No: <Organisation Details>** | **Fax No: <Organisation Details>** | |
| **Date Seen by GP: <Today's date>** | | |

**Reason for referral including any previous ontological problems** *(please include any hear check results)***:**

**I confirm this patient: (please tick)**

If the patient was offered a hearing aid they would be happy to wear one

Has both ears clear of all wax

Has intact and healthy ear drums

Does not report fluctuating hearing loss, ear pain longer than 7 days or discharge within 90 days

Does not report unilateral hearing loss and/or unilateral or troublesome tinnitus

Does not report sudden onset or rapid deterioration of hearing loss

Does not report suffering with dizziness (vertigo)

*If wax is present – please ensure patients ears are clear of wax prior to referral as the patient will be offered an appointment within 20 working days.*

**Previous Audio-logical care:**

|  |  |  |
| --- | --- | --- |
| Date of last **NHS** hearing assessment *(dd/mm/yy)* | or N/A | |
| Has the patient had a previous hearing aid? *If yes, please complete the questions 1-3* | | **Yes/No** |
| 1. Has the patient been referred for a **NHS** hearing assessment since April 2013? | |  |
| 2. Has the patients hearing changed since the last assessment? | |  |
| 3. Does the patient require maintenance of their hearing aid? | |  |

**Relevant Past Medical History and Medication:**

**Other considerations (such as any ear operations, a learning disability, mobility or language needs):**