**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**

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| --- |
| **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):**