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| Please return the completed form via email (preferred) to: [**gst-tr.audiologyappointments@nhs.net**](mailto:gst-tr.audiologyappointments@nhs.net) or post to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Adult Audiology Centre**  **Guy’s** **Hospital, 3rd Floor Southwark Wing**  **Great Maze** **Pond, London T: 020 7188 2211**  **SE1 9RT** | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **Direct Referral to Adult Audiology Centre** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Note:*** This form may only be used for patients with suspected hearing loss. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If the patient fails any of the criteria below, please refer to ENT first. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referring GP Name: | | | | | | | | | |  | | | | | | | | | | | | | | Address: | | | | |  | | | | | | | | | | | | | |
| Tel. Number: | | | | |  | | | | | | | | | | | | | | | | | | |
| Email: | |  | | | | | | | | | | | | | | | | | Pref. Correspondence Method: | | | | | | | | | | | | | | Email | | | | | | Post | | | |
| Date of Referral: | | | | | | | | | |  | | | | | | | | | Urgency of Referral: | | | | | | | | | | | | | | URGENT | | | | | | ROUTINE | | | |
| Transport Required? | | | | | | | | | | Yes | | | | | | No | | | Is Patient Housebound? | | | | | | | | | | | | | | Yes | | | | | | No | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | |  | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | |
|  | | | Title | | | | | | First | | | | | | | | | | | | | Middle | | | | | | | | | | | | Last | | | | | | | | |
| Preferred Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | NHS Number: | | | | | | | |  | | | | | | | | |
| Date of Birth: | | | | | |  | | | | | | | | | Gender: | | | M  F Other: | | | | | | | | | | Pronoun Pref.: | | | | | | | He | | | She | | | They | |
| **(Patient must be at least 18 years old)** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postal Code: | | | |  | | | | | | | | | Interpreter Required: | | | | | | | | | | Yes | | | | No | | | Language: | | | | | |  | | | | | | |
| Email: |  | | | | | | | | | | | | | | | | | | | | | | | | | Primary Tel.: #: | | | | |  | | | | | | | | | | | |
| Pref. Contact Method: | | | | | | | | | | | Phone | | | | | | Email | | | Post | | | | | | Other Tel.: #: | | | | |  | | | | | | | | | | | |
| Next of Kin (NOK): | | | | | | | | | |  | | | | | | | | | | | | | | | | NOK Tel.: | | | | |  | | | | | | | | | | | |
| Any Disability? | | | | | | | Physical | | | | | | | Cognitive | | | | | | | Learning | | | | | | Blind | | | | | Deaf | | | | | Other: | | |  | | |
| Carer Name and Contact Details (if applicable): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **To be suitable for Direct Referral, the patient must have NONE of the following:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **(Please fill the box to the right of each statement to confirm verification of criteria)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **NO** |
| *Wax* in either ear (patient’s ears must be clear before referring). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Persistent pain* affecting either ear, lasting a week or more within the last 90 days. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Discharge* from either ear within the last 90 days which has not responded to treatment, or which is recurrent. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Reported *asymmetry in hearing.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Abnormal appearance* of the outer ear and/or the eardrum (e.g., inflammation of the auditory canal, perforated tympanic membrane or active discharge). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Tinnitus* that lasts longer than 5 minutes at a time, which is unilateral, pulsatile, has significantly changed in nature, is leading to sleep disturbance, or is associated with symptoms of anxiety or depression. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Rapid deterioration* of hearing (rapid = deterioration over 4-90 days1). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Facial numbness*, weakness, paralysis, or facial droop. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Fluctuating hearing loss*, other than associated with colds, lasting more than 90 days. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *Vertigo/dizziness*, which has not fully resolved or is recurrent. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| *1If patient reports sudden hearing loss within 72 hours, please send to A&E or Urgent Care ENT Clinic:*  *Phone: 020 7188 2215 Email:* [*gst-tr.entaccessteam@nhs.net*](mailto:gst-tr.entaccessteam@nhs.net) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please attach any relevant medical history or correspondence to this referral. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |