# HEARING ASSESSMENT CLINICS HELD AT NEW STREET HEALTH CENTRE REFERRAL REQUESTS

Name: ............................................................................................................

Date of Birth: ........................................ NHS Number: ........................................

Address: ............................................................................................................

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Telephone Number: ........................................ Post Code: ........................................

GP: ........................................ School Attending (if any) ........................................

Referred By: ........................................ Results to be sent to: ........................................

**PROFESSIONALS INVOLVED WITH THE CHILD: (Please list below)**

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**REASONS FOR REFERRAL: (Please ring where appropriate)**

1. Low Birth Weight(Prem less than 33 wks
2. Asphyxia at Birth
3. Neonatal Jaundice
4. MaternalRubella/Cytomegalo Virus
5. Familial Deafness
6. Congential Defect/Chromosomal Defect
7. ABR Follow Up (Targeted NHSP)
8. Recurrent Respiratory Infections
9. Suspected Deafness
10. Speech and Language Delay
11. Learning Disorder
12. Delayed Development (not speech)
13. Worried Parents/School
14. Past History of ENT Problems Treatment
15. Others (specify below)

Additional Information: ............................................................................................................

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Signed: ........................................ Designation: ........................................

Date: ........................................