**GROMMETS FOR OTITIS MEDIA WITH EFFUSION IN CHILDREN REFERRAL FORM**

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| **\*To:** |  **Referral Date:** **<Today's date>** |
| **\*Specialty:**       | **\*Sub Specialty** (*if appropriate)*:       |
| **\*Provider Booking Department** (*Insert provider organisation*):       |

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| **Patient Details** | **GP Details** |
| **Forename:** | <Patient Name> | **Referring GP:**  | <GP Name> |
| **Surname:** | <Patient Name> | **Registered GP:** | <GP Name> |
| **Date of Birth:** | <Date of birth> | **Practice:** | <Organisation Details><Organisation Address> |
| **NHS No:** | <NHS number> |
| **Gender:** | <Gender> |
| **Ethnicity:** | <Ethnicity> |
| **Hosp No** (if known)**:** |       |
| **Address:** | <Patient Address> |
| **Telephone:** | <Organisation Details> |
| **Fax:** | <Organisation Details> |
| **Practice code:** | <Organisation Details> |
| **Home Tel No:** <Patient Contact Details>**Work Tel No:** <Patient Contact Details>**Mobile Tel No:** <Patient Contact Details> |

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| **CLINICAL THRESHOLD - Grommets for Otitis Media with Effusion in children** |
| **Instructions for use:**Please refer to policy for full details, complete the checklist and file for future compliance audit.The CCG will only fund Grommets for Otitis Media with Effusion in children when the following

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| *In ordinary circumstances\*, referral should not be considered unless the patient meets* ***one or more*** *of the following criteria when presenting in a Primary Care setting:* | Tick as appropriate |
| Recurrent acute otitis media - 5 or more recorded episodes in the preceding 12 month period. | [ ]  Yes[ ]  No |
| Suspected hearing loss at home or at school / nursery | [ ]  Yes[ ]  No |
| Speech delay, poor educational progress due to the hearing loss following 3 months of watchful waiting | [ ]  Yes[ ]  No |
| Abnormal appearance of tympanic membrane | [ ]  Yes[ ]  No |
| *In ordinary circumstances\*, procedure should not be considered unless the patient meets* ***one or more*** *of the following criteria when presenting in Secondary Care setting:* | [ ]  Yes[ ]  No |
| Persistent hearing loss for at least three months (in any setting) with hearing levels of:* 25dBA or worse in both ears on pure tone audiometry **OR**
* 25dBA or worse or 35dHL or worse on free field audiometry testing **AND**

Type B or C2 tympanometry | [ ]  Yes[ ]  No |
| Suspected underlying sensorineural hearing loss  | [ ]  Yes[ ]  No |
| Atelectasis of the tympanic membrane where development of cholesteatoma or erosion of the ossicles is a risk. | [ ]  Yes[ ]  No |
| OME in the presence of a secondary disability e.g. autistic spectrum disorder, Down syndrome, cleft palate. | [ ]  Yes[ ]  No |
| Persistent OME (more than three months) with fluctuating hearing but significant delay in speech, educational attainment or social skills. | [ ]  Yes[ ]  No |

 *If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.**As the presence of a second disability such as Down’s syndrome or cleft palate can predispose children to OME in such children it is left to the clinician’s discretion how far this policy will apply.*  |

**PLEASE NOTE:** Secondary Care to reject referral if this form is not complete and return patient to Primary Care.

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| Dear Colleague, Thank you for kindly seeing this patient.**Presenting Complaint**     **Relevant Clinical Findings**     **Action to be Taken**     I have attached my recent consultation herewith which is also self-explanatory. I will appreciate your assessment and advice. Many thanks.<GP Name> |

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| **\*Interpreter required?** **[ ]** Yes/[ ]  No**.** **If yes, please state which language:**       |

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| **MEDICAL HISTORY*** **History**

Active Problems<Problems(table)>Significant Past<Problems(table)>* **Last Consultation/s**

<Event Details(table)>* **Current medication:**

Acute<Medication(table)>Repeat<Medication(table)>* **Blood Pressure:**

<Last 5 BP Reading(s)(table)>* **Alcohol Consumption**

<Numerics>* **Current allergies**

<Allergies & Sensitivities(table)> |

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| **LABORATORY RESULTS (Latest result within last year unless stated)**Lipids**Glucose / HbA1c**Liver Function TestsRenal / Prostate FunctionHaematologyThyroid FunctionUrinalysisPeak Flow**Histology / ECG / Radiology (Last 2 years)**  |