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St George's University Hospitals NHS
NHS Foundation Trust

Referral Form: Paediatric to Adult Audiology Transition Service

We accept direct referrals to our paediatric to adult audiology transition service subject to hearing loss being investigated and supporting information being provided. Please complete this form in as much detail as possible, **failure to complete * sections** will result in referral being returned or the referral being redirected to audiological physician adult hearing services. We accept referrals from any professional working with a hearing impaired/Deaf/deaf young adult aged 16-25 years old being in full time education.

* Referrer Details (Please print details in block capitals):

Referrer Name:		**Referrer Designation:**	
Referrer Address: **Contact Tel/Email:**			
Referral Date:		**Received Date:**	

* Patient Details (Please print details in block capitals):

Patient Name:		**Patient Address:**	
NHS Number:			
D.O.B:			
Main Communication Method: Interpreter required: Y☐ / N☐	☐ BSL ☐ ☐ SSE (Sign Supported English) ☐ Spoken English ☐ Non-English Language (specify): _____ Other (specify): _____	**Patient contact details:** *Preferred contact method (Tick):* *Phone* ☐ / *Text* ☐ / *Email* ☐	**Phone:** **Mobile:** **Email:**
Transport Required:	Y / N	**Parent/Guardian Name:**	
Borough/County:	Bexley ☐ /Bromley ☐/ Croydon ☐/ Greenwich ☐/Kent ☐/ Kingston ☐ Lambeth ☐ /Lewisham ☐ /Merton ☐ /Richmond ☐ /Southwark ☐ /Surrey ☐ Sutton ☐ Wandsworth ☐ Other: _____		
Relevant medical history:	Please give details of additional health complaints/complex needs e.g. downs syndrome, learning difficulties, cerebral palsy, dual sensory disabilities.		

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* Paediatric Audiology Service Details:

Name of Department:			
Address of Department:			
Date Hearing Loss Identified:		**Planned Transition Age:**	

Please enclose copy of most recent audiology report.

* Most Recent Hearing Assessment:

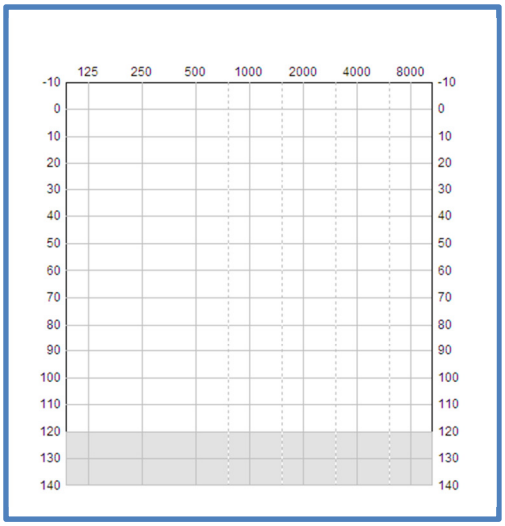
Date of last hearing test:		**Test Method:**	☐ABR ☐ PTA ☐Play Audiometry ☐VRA ☐ BOA ☐ Other (describe: _____)
Comments on test method/reliability:			

Otoscopy:	Right:	Left:
Tympanometry:	Right:	Left:
Otoacoustic Emissions:	Right:	Left:

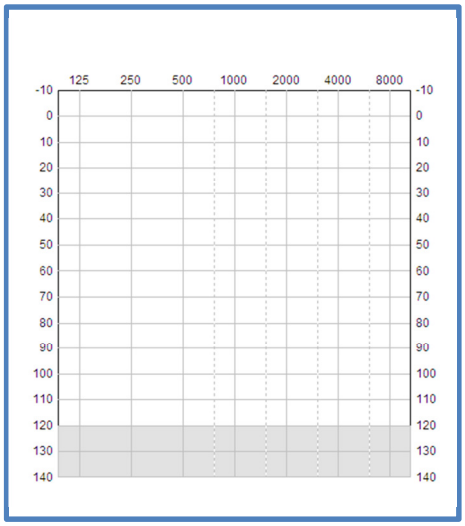
Hearing Thresholds: [mark (m) for all masked thresholds]
Thresholds measured in: dBHL ☐ / dBA ☐
Transducer: ☐NA ☐ Insert Tip ☐ Insert coupled to earmould ☐TDH headphones

	125Hz	250Hz	500Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Soundfield:									

Right:



Left:



* Amplification Details:

Current amplification:	Right only ☐ / Left only ☐/ Bilateral ☐/ (Bi)CROS ☐ / None ☐	
Make & Model:	Right:	Left:

Device Type:	Right: ☐ BTE / ☐ ITE / ☐ N/A	Left: ☐ BTE / ☐ ITE / ☐ N/A
Date amplification fitted:	Right:	Left:
Earmoulds/Open Fit:	Right ear: earmould ☐ / Open Fit ☐	Left ear: earmould ☐ / Open Fit ☐

Earmould details: (If applicable)

	Earmould type:	Tube type:	Vent Size:	Modifications: (e.g. tube lock)
Right ear				
Left ear:				

Open fit details (if applicable)

	Size:	Dome/custom Top details:
Right ear:		
Left ear:		

Hearing aids Settings:

Prescription	Programs:	Volume control:	Comments on features e.g. NLFC active/e2e disabled:	Date last verified through REMs:
	P1: P2: P3:			

If using Phonak hearing aids on target platform, please export to file a copy of the latest settings and email them across from NHS.Net to NHS.Net to: **stgh-tr.audiology@nhs.net**

Education, Work & Training Plans:

Currently in:	☐ Work / ☐ Education ☐ Training Details:	**If Education/Training when will this finish:**
Please give details of future plans for work & education:		
Current Living Situation:	Living with parents ☐ / Living independently ☐ / University ☐ / Assisted living facility ☐ / Full time care facility ☐ **Details:**	
Keyworker: *Name & Contact details:*		

Parent/guardian with parental responsibility / Legal guardianship/Power of Attorney	Name: Address: Contact Tel No:

* *Previous Otology Episodes & Aetiological Investigations:*

Previous ear surgeries:	**Y ☐ / N ☐ Details:**	
	Currently under care of ENT: Y ☐ / N ☐	
Aetiological investigations completed:	**Y ☐ / N ☐ Date referred for investigations:**	
	Details of outstanding investigations:	
	Reason if not completed:	
	Clinician who completed investigations:	
Cause of hearing loss:		
Aetiological Investigations results:	**Blood Tests:**	
	CMV:	
	Genetics:	
	MRI/CT Scan:	
	Opthalmology:	
	Kidney Scan:	
	Other (specify):	

* *Health and Care Professions involved in patients care (consent from patient should be obtained before information is shared below):*

Sensory Support Service:	Borough/County Named TOD Contact Address Contact Tel

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Speech & Language:	Borough/County Name of Therapist Contact Address Contact Tel
Paediatrician:	Name Contact Address Contact Tel
Social Worker:	Name Contact Address Contact Tel
ENT:	Name Contact Address Contact Tel
Other: Please add as many additional entries as required:	

For audiology administrative use only:

Referral accepted: Y / N Date Received: _____

Triage Date:	**Triaged by:**	**Triaged to:** Paediatric Clinic: ☐ Paed Simple / ☐ Paed Complex Transition Clinic: ☐ Transition Group / ☐ Complex Needs Adult Services: ☐ AA / ☐ Hearing / ☐ AVP Hearing / ☐ LDC	☐ **Sent to CBS** ☐ **Added to dept W/L**