AUDIOLOGY REFERRAL FORM

Please note – we are unable to accept referrals for patients under 3 years of age

PATIENT		**REFERRER**		
ID/ NHS Number		Name		
Forename		GMC/HPC/NMC No		
Surname		Address		
Address				
Date of Birth		Referring PCT Code		
Telephone (Home)		Referring Practice Code		
Telephone (Work)		Telephone No. **(for urgent clinical findings)**		
Telephone (Mobile)		Fax No.		
E-mail		E-mail		
Gender	Male ☐ Female ☐	Preferred Site for Referral	Marylebone ☐	LIH ☐
Physical/Communication difficulties (specify if any):		Wheelchair user?	Yes ☐	
If interpreter required, language:		The patient must be ambulant, or if a wheelchair user they must be able to transfer independently onto the examination couch.		
Ethnicity				

PRESENTING COMPLAINT & PROVISIONAL DIAGNOSIS

Please provide as much relevant clinical information as possible to assist with the interpretation of the referral and results.

Date of referral

SERVICE REQUESTED	PTA ☐	ULL ☐	TYMP ☐
	HEARING AIDS ☐	TINNITUS CLINIC ☐	WAX REMOVAL ☐

Has the patient previously been fitted with a hearing aid?	Yes ☐ No ☐
Date of last hearing assessment	
If previous hearing assessment in last six months, please attach results.	

Please fax or e-mail this form to London Ear Centre:
Tel: 0203 675 9985 Fax: 0203 675 9986 E-mail: info@londonearcentre.com
www.londonearcentre.com

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