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				
Telephone (Home)				
Telephone (Work)		Telephone No. **(for urgent clinical findings)**		
Telephone (Mobile)		Fax No.		
E-mail		E-mail		
Gender	Male ☐ Female ☐	Preferred Site for Referral	Marylebone ☐	Canary Wharf ☐
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

ACTIVITY REQUESTED

HEARING	PTA ☐	TYMP ☐	ART ☐	SPEECH IN NOISE ☐	HEARING AIDS ☐	OTHER (Please specify):
BALANCE	VNG ☐	CALORICS ☐	VHIT ☐	VEMPS ☐	BPPV/ VEST. REHAB ☐	
OTHER	TINNITUS ☐	CUSTOM EAR PLUGS ☐	WAX MICROSUCTION ☐			

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 hand this form to reception or e-mail it to London Ear Centre:
Tel: 0203 675 9985 E-mail: info@londonearcentre.com
www.londonearcentre.com