**Referral for Auditory Implant Assessment**

Please select the procedure for which the patient is being referred

Bone Conduction Hearing Implant (BCHI) [ ]

Bone conduction hearing device (BCHD) – non surgical [ ]

Middle ear implant (MEI) [ ]

Cochlear implant (CI) [ ]

*NB to select a box, double click and select “check” then “ok”*

**Please include a covering letter detailing the patient’s background, history of diagnosis, hearing aid use and any other relevant details.**

The following information is required by the Auditory Implant Service

|  |  |
| --- | --- |
| **Requirement** | **Patient Details** |
| First name |  |
| Last name |  |
| NHS number |  |
| Date of birth |  |
| Address |  |
| Post code |  |
| Parent/carer names (if applicable) |  |
| School name and address (for all school age children) |  |
| Contact details, e.g. phone, text, email  |  |
| Access needse.g. mobility or interpreter |  |
| Referrer name, address and post code |  |
| GP name, address and post code  |  |

Please provide us with as many of the following as possible. Please provide any other information that you think would be useful.

|  |  |
| --- | --- |
| **Information needed** | **Notes** |
| Most recent aided and unaided audiograms\* |  |
| Previous audiograms\*\* |  |
| Copy of traces of electrophysiological measurements e.g. ABR, OAEs’, CM\*\*\* |  |
| Copy of hearing aid details and settings |  |
| Speech perception test results (Desirable for BCHI)\* |  |
| Aetiological tests and results (or date of planned testing)ECG and report\*\*\*\*OphthalmologyBlood tests |  |
| Details of previous scans.Enclose copy of scan disks and scan results |  |
| For BCHI/BCHD/MEI - Details of hearing aid trial, reasons why patient cannot use air conduction or CROS hearing aids, history of ear infections (particularly in last 1-2 years).\*  |  |
| Any other information |  |

* Needed to process referral – referral will not be accepted before this information is obtained

\*\* If hearing loss is progressive – but always required for BCHI

\*\*\* Tympanometry results at time of testing are required

\*\*\*\*ECG tests and report are essential for congenitally deaf children

Please return to:

Referrals Team, FREEPOST, RTHT-TBHY-ZJJR, University of Southampton, Auditory Processing Service, B19 Highfield, Southampton SO17 1YN

Email: ais.referrals@soton.ac.uk

*(****please note this is not a secure email so please encrypt any patient identifiable information*** *– please contact us for more information)*