Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

(Aud1) COMMUNITY AUDIOLOGY ADULT REFERRAL FORM
(Medical Card Holders only)

Please ensure ALL relevant sections are complete & consent received from Client
Referral to this service is for audiological assessment and hearing aid fitting only, and not for medical/legal cases.
(BLOCK CAPITALS ONLY)

Please return to
HSE Audiology Service
1st Floor
Vista Primary Care
Naas
Co. Kildare
Tel: 045 986854

Section 1: Client Personal Details

Surname:	First name:
Gender: Male ☐ Female ☐	DOB: Age:
Address:	
Medical Card No:	Medical Card Review Date:
Contact Person:	Relationship to client:
Telephone/Mobile:	Text Message YES ☐ NO ☐
Email address *(optional)*	Consent to receive: Emails YES ☐ NO ☐
GP Name/Practice	Contact Number for GP
GP Address:	

Section 2: To assist our prioritisation process, please tick below as appropriate:

- ☐ Client has a terminal illness
- ☐ Client is receiving Ototoxic treatment e.g. Chemotherapy for cancer
- ☐ Client has a hearing loss due to Meningitis/Hepatitis C/HIV
- ☐ Client has sudden onset confirmed hearing loss bilaterally (>70dB average over 4 frequencies) Please enclose audiogram
- ☐ Client has two or more co-existing impairments e.g. hearing loss and blindness
- ☐ Client has special needs
- ☐ Client is a carer of a person with disabilities
- ☐ Client has significant medical illness such as CVA
- ☐ Client is over 80 living alone with no family members
- ☐ Client has impaired mobility (such as wheelchair user, confined to bed in a nursing home/community hospital or at their own home

For office use:
(Please circle)
Priority
Routine

Section 3 Relevant History:

Does the client suffer from ear aches/infections?	YES ☐ NO☐	Is there any history of perforations? YES ☐ NO ☐
Are the client's ears occluded with wax?	YES ☐ NO☐	*(An impression cannot be taken of an ear if the ear canal is occluded with wax)*
Does the client suffer from tinnitus?	YES ☐ NO☐	Has the client suffered from vertigo? YES ☐ NO ☐
Has this client ever worn a hearing aid?	YES ☐ NO☐	If so, from whom did they receive the hearing aid?
Has this client ever attended an ENT specialist?	YES ☐ NO☐	If yes, what hospital/consultant?
Has the client had any surgical procedures carried out on his/her ears?	YES ☐ NO☐	If so, please specify.
Is there any other relevant medical/family history or additional information?		

Section 4: MEDICAL PRACTITIONER RECOMMENDATION: The referral will NOT be processed without this.
I, the undersigned, would like to refer the above named to your clinic for audiological assessment.

Medical Practitioner Signature:	Title:	Date:
Has the client consented to this referral? YES ☐ NO ☐	Doctors Stamp:	
Has the client consented to sharing of information? YES ☐ NO ☐		

FOR YOUR INFORMATION:

As part of our ongoing commitment to delivering high quality care, these notes may be used for Quality Improvement. No identifying information is used in this process. However if you would prefer that this information is not used, please tick: ☐ This will not affect the care given in any way.

OFFICE USE ONLY:

Comment:	Signed:	Date:

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

(Aud 2) ENT REFERRAL FORM TO COMMUNITY ADULT AUDIOLOGY (Medical Card Holders only)

Please return to:

Please ensure ALL relevant sections are complete & consent received from Client
Referral to this service is for audiological assessment and hearing aid fitting only, and not for medical/legal cases.
(BLOCK CAPITALS ONLY)

Please attach hospital label here :	*Community Audiology Label*
Medical Card No:	Medical Card Review Date:
Contact Person:	Relationship to client:
Telephone/Mobile:	Consent to receive Text Message YES ☐ NO ☐
Email address *(optional)*	Consent to receive: Emails YES ☐ NO ☐
GP Name/Practice	Contact Number for GP
GP Address:	

Section 2: To assist our prioritisation process, please tick below as appropriate

- ☐ Client has a terminal illness
- ☐ Client is receiving Ototoxic treatment e.g. Chemotherapy for cancer
- ☐ Client has a hearing loss due to Meningitis/Hep C/HIV
- ☐ Client has sudden onset confirmed hearing loss bilaterally (>70dB average over 4 frequencies) Please enclose audiogram
- ☐ Client has special needs
- ☐ Client has two or more co-existing impairments e.g. hearing loss and blindness
- ☐ Client is a carer of a person with disabilities
- ☐ Client has significant medical illness such as CVA
- ☐ Client is over 80 and living alone with no family members
- ☐ Client has impaired mobility (such as wheelchair user, confined to bed in a nursing home/community hospital or at their own home

For office use: (please circle)
Priority
Routine

Section 3: Relevant History

Is there any history of perforations/discharge?	YES ☐ NO☐	Has the client suffered from vertigo? YES ☐ NO ☐
Does the client suffer from tinnitus?	YES ☐ NO☐	*NB: PLEASE ENSURE WAX IS REMOVED BEFORE REFERRAL*

Has the client had any surgical procedures carried out on his/her ears? YES ☐ NO☐ Please specify:

Is there any other relevant medical/family history or additional information

Section 4: ENT CONSULTANT / REGISTRAR RECOMMENDATION: The referral will NOT be processed without this.

I, the undersigned, would like to refer the above named to your clinic for audiological assessment, fitting of hearing aid and habilitation.

Name of ENT Consultant / Referring Hospital:

Signature ENT Consultant / Registrar:	Title:	Date:

Has the client consented to this referral? YES ☐ NO ☐ Has the client consented to sharing of information? YES ☐ NO ☐

Is Audiogram attached: YES ☐ NO ☐ Hearing Aid : R ☐ L ☐

Section 5: FOR YOUR INFORMATION:

As part of our ongoing commitment to delivering high quality care, these notes may be used for Quality Improvement. No identifying information is used in this process. However if you would prefer that this information is not used, please tick: ☐ This will not affect the care given in any way.

OFFICE USE ONLY:

Comment:	Signed:	Date: