

**AUDIOLOGY SELF-REFERRAL FORM (ADULTS)**

**Please complete all sections of the form and return to the Audiology Department at Royal Bolton Hospital via post, email or the online version of this form using the contact details included in the table below. If downloading the form from the Trust webpage, please complete the form and save to your device, then email** [**audiology@boltonft.nh.uk**](mailto:audiology@boltonft.nh.uk) **with the form as an attachment**

**If you have any difficulties competing the form please contact the department directly as we will be able to assist you in completing the form.**

**We cannot accept referrals if you have any of the following problems and you will need to contact your GP**

**Sudden onset hearing loss**

**Ear infections**

**Pain in the ear(s)**

**Fluctuating hearing loss**

**Vertigo**

|  |  |
| --- | --- |
|  | **Contact Details** |
|  | Address:  Audiology Department  Royal Bolton Hospital  Minerva Road  Farnworth  Bolton  BL4 0JR |
|  | Telephone: 01204 390435 |
|  | Email: audiology@boltonft.nhs.uk |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Details** |  | | | | |
| **Surname** |  | | | | |
| **Forename** |  | | | | |
| **Title** |  | | | | |
| **NHS Number** |  | | | | |
| **Date of Birth** |  | | | | |
| **Gender** | Male | | Female | | |
| **Ethnicity** |  | | | | |
| **Address** |  | | | | |
| **Postcode** |  | | | | |
| **Phone Numbers:** |  | **Preferred number** | | **Can leave messages** | **Carer’s details** |
| **Home** |  |  | |  |  |
| **Work** |  |  | |  |  |
| **Mobile** |  |  | |  |  |
| **Patient Email** |  | | | | |
| **Communication Needs (e.g. interpreter)** | Yes | | No | | |
| **provide details:** |  | | | | |
| **Disability** | Yes | | No | | |
| **provide details:** |  | | | | |
| **Learning Difficulty** | Yes | | No | | |
| **Dementia** | Yes | | No | | |
| **Carer details (if applicable)** |  | | | | |
| **Domiciliary Need** | Yes | | No | | |
|  |  | | | | |
| **GP Details** |  | | | | |
| **GP Practice Name** |  | | | | |
| **GP Name** |  | | | | |
| **GP Practice Telephone** |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Relevant past medical history** – pleaseinclude previous and current treatment/medication that you feel may be relevant to your hearing assessment or anything else about your medical history that you think the provider should be aware of. | | | |
| **Have you previously been fitted with a hearing aid?**  **If yes, and this has been within the last 3 years, please contact your provider to discuss any issues you may be having with your current devices.** | | | **Yes**  **No** |
|  | | | |
|  |  | **Date of Request** |  |