Pindrop HEARING

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AUDIOLOGY REFERRAL FORM

Patient Details

Name: _____

DOB: _____

Address: _____

Telephone: _____

Email: _____

Insurance: _____

Referrer Details

Referring clinician: _____

Address: _____

Telephone: _____

Email: _____

Date of next appointment with clinician: _____

Preferred Location

- ☐ No Preference
- ☐ Harley Street
- ☐ Winchmore Hill
- ☐ Finchley Road
- ☐ Chelsea
- ☐ Little Chalfont
- ☐ Spire Bushey

Tests Or Services Required (please tick)

Diagnostic Audiology

- ☐ Pure Tone Audiometry
- ☐ Speech Audiometry
- ☐ Tympanometry
- ☐ High Frequency Audiometry
- ☐ Stapedial Reflexes
- ☐ Otoacoustic Emissions (OAE)

Vestibular Testing

- ☐ Full Test Battery
- ☐ Calorics and VNG
- ☐ Dix Hallpike Video Recording
- ☐ Video Head Impulse Test (VHIT)
- ☐ C-VEMP
- ☐ O-VEMP

Paediatric Hearing Assessment

- ☐ Visual Reinforcement Audiometry (VRA)
- ☐ Conditioned Play Audiometry
- ☐ Auditory Processing Disorder (APD)

Parent or guardian name: _____

Relationship to patient: _____

Telephone: _____

Email: _____

Hearing Rehabilitation

- ☐ New Hearing Aid Assessment
- ☐ Hearing Aid Review
- ☐ Cochlear Implant Assessment
- ☐ Speech In Noise Tests
- ☐ Tinnitus Assessment And Rehabilitation
- ☐ Lyric Hearing Aid Assessment

Earmoulds and Hearing Protection

- ☐ Swimmers Ear Moulds
- ☐ Noise Protection
- ☐ Sleep Plugs
- ☐ Musicians Ear plugs

Ear Wax Removal

- ☐ Microsuction
- ☐ Irrigation
- ☐ Clinician to decide

Reason for referral and other relevant patient history

Please email to **info@pindrophearing.co.uk**

Please send more referral forms ☐