

(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 15	Client Personal	Details			
Surname:		First name:		×	
Gender: Male Female		DOB:	3: Age:		
Address:					8
Medical Card No:	Medical Card Review Date:				
Contact Person:		Relationship to client:			
Telephone/Mobile:		Text Message YES NO NO			
Email address (optional)		Consent to receive: Emails YES NO			
GP Name/Practice		Contact Number for GP			
GP Address:					
Section 2: T Client has a terminal illness Client is receiving Ototoxic treatment e.g. Che Client has a hearing loss due to Meningitis/H Client has sudden onset confirmed hearing los Client has two or more co-existing impairment Client has special needs Client is a carer of a person with disabilities Client has significant medical illness such as C Client is over 80 living alone with no family me Client has impaired mobility (such as wheelch	epatitis C/HIV ss bilaterally (>70dB ave ts e.g. hearing loss and CVA embers	erage over 4 frequenc blindness	ies) Please enclose au	adiogram	For office use: (Please circle) Priority Routine
		nt History:			
Does the client suffer from ear aches/infections?	YES NO	Is there any history	of perforations? YE	S D NO D	
Are the client's ears occluded with wax?	YES NO	(An impression can	not be taken of an ear if	the ear canal is occlu	ded with wax)
Does the client suffer from tinnitus?	YES NO	(An impression cannot be taken of an ear if the ear canal is occluded with wax) Has the client suffered from vertigo? YES \(\simega\) NO \(\simega\)			
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 hospita	l/consultant?		1
Has the client had any surgical procedures carried Is there any other relevant medical/family history of		1 1 2 2	If so, please specify		
Section 4; MEDICAL PRAC	CTITIONER RECOM	MENDATION: The	eferral will NOT be pr	ocessed without this	
	would like to refer the a	点是特殊的。 第一种,是一种,是一种,是一种,是一种,是一种,是一种,是一种,是一种,是一种,是			
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			1.75	
BOR YOUR INFORMATIONS As part of our ongoing commitment to delivering his However if you would prefer to	hat this information is no	t used, please tick:	lity Improvement. No] This will not affect th	identifying informati ne care given in any v	on is used in this process. way.
OFFICE USE ONLY:	and the second of the second o		u. La spiloj propintiĝoj kal	ti Maria Katiro	in Angles in production (1984)
Comment:		Sign	ed:	Date:	

Please return to:



(Aud 2) ENT REFERRAL FORM TO COMMUNITY ADULT AUDIOLOGY

(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)

	A POST OF THE STATE OF THE STAT					
Please attach hospital label here ;		Community Audiology Label				
M. disal Cord No.		Medical Card Review Date:				
Medical Card No: 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:						
To	esist our prioritisation r	process, please tick below as appropriate				
Section 2: To a	issist our prioritisation 1					
Client has a terminal illness						
Client is receiving Ototoxic treatment e.g. Che			For office use:			
Client has a hearing loss due to hemights/12p 0/12. Client has sudden onset confirmed hearing loss bilaterally (>70dB average over 4 frequencies) Please enclose audiogram (please circle)						
						☐ Client has special needs ☐ Client has two or more co-existing impairment
Client is a carer of a person with disabilities			Routine			
☐ Client has significant medical illness such as C	CVA		<u> </u>			
Client is over 80 and living alone with no family	y members					
Client has impaired mobility (such as wheelcha	air user, confined to bed	l in a nursing home/community hospital	or at their own home			
Client has impaired mobility (such as wheelcha	air user, confined to bed Relevant	transport and the state of the	or at their own home			
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