BEAUMONT
HOSPITAL

Cochlear Implant Assessment Referral Form

* (mandatory field)

Demographics

Patient Details

* Surname
* Forename
Middle Name
* DOB
* Address

Email
* Phone

General Practicioner Details

* Name
* Address

* Email
* Phone

Next of Kin Details

* Name
* Relationship
* Address

Email
* Phone

Audiologist Details

* Name
* Address

* Email
* Phone

Is your patient attending an ENT Surgeon currently? Yes No

If yes, please provide details:

Name
Address

Email
Phone

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Is your patient attending a speech and language therapist currently? Yes ☐ No ☐

If yes, please provide details

Name ____

Address ____

____

____

____

Email ____

Phone ____

Details of Hearing Loss

What is the type of hearing loss? Congenital ☐ Acquired ☐
(Proceed to section A if congenital, B if acquired)

A. If congenital, did your patient have universal neonatl hearing screening (UNHS)?

Yes ☐ No ☐ Where and when? ____

B. If acquired, what was the onset of hearing loss?

Sudden ☐

Progressive ☐, over what period? ____

Progressive ☐, but seriously deteriorated in the last ____ months/years

When did your patient notice the hearing loss? ____

When was the diagnosis of hearing loss made? ____

* *Please provide us with a copy of the most recent audiogram (within the last months)*

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If your patient is a child, has the child been referred to a paediatrician to investiage the cause of hearing loss? Yes ☐ No ☐

If yes, please provide details of the paediatrician (name, hospital)

Does your patient suffer from (choose one or more); and provide details of each of the sypmtoms

- Tinnitus
- Chronic/recurrent otorrhoea
- Vertigo
- Otalgio

Is there a known cause for your patient's hearing loss? Yes ☐ No ☐

Has your patient had imaging to investigate cause of hearing loss in the last 3 years? (If yes, please provide details and/or copy of report) Yes ☐ No ☐

Please also include any other reports or documentation which can be helpful in the screening process? (e.g. genetic testing, SLTs reports, teacher's report, psychologist reports etc.)

History of Hearing Aids

* Has your patient been fitted with hearing aids? Yes ☐ No ☐

(Proceed to section A if congenital, B if acquired)

* When? * Which Side? Bilateral ☐ Left Only ☐ Right Only ☐

* *Please provide us with the most recent report of hearing aid review (within the last months)*

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* Is your patient wearing both hearing aids regularly (i.e. worn most of the time when patient is awake)? Yes [ ] No [ ]

if no, which side is worn?

Right [ ] Left [ ] Both but not worn regularly [ ] Stopped wearing both [ ]

Tell us the reason for not wearing both hearing aids regularly

For how long has your patient stopped wearing hearing aids regularly?

years / months

Medical History

Has your patient had major ear surgery in the past? Please provide details and indication for the surgery

Please list your patient's complete medical co-morbidities OR provide copy of the list

Please list your patient's active medication OR provide copy of the list (please highlight anti-coagulants and ACE inhibitors)

Does your patient have any allergy or sensitivities to medication?

Please list any special circumstances requiring additional care (e.g. limited mobility, learning disability, dementia, claustrophobia, etc.)

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Does your patient have any allergy or sensitivities to medication?

Please list any special circumstances requiring additional care (e.g. limited mobility, learning disability, dementia, claustrophobia, etc.)

Disclaimer:

All fields marked with asterisk are mandatory. Submission of the referral is not possible unless all mandatory fields are completed.

Declaration:

* I hereby confirm that all the information provided is true and accurate to my knowledge and I am responsible to ensure ther accuracy of the information above.

* I have read and fully understand the referral guidelines and criteria for cochlear implant assessment. I have discussed the referral with my patient (and the next of kin) and obtained consent for referral.

Referrer

* **I am a -** GP Audiologist ENT Surgeon ENT NCHD

* Title
* Name
* Address
* Email
* Phone
* Medical Council / Irish Academy of Audiologist Registration Number
* Supervising consultant (if referrer is an ENT NCHD, otherwise fill in as N/A