**Self-Referral Form – Community Audiology Service for Age Related Hearing Loss 50 years+ Lancashire and South Cumbria**

Please complete this form to access the self-referral community audiology service in Lancashire and South Cumbria.

If you have difficulties completing this form, please contact your provider of choice directly. They will be able to help you to complete this form.

Are you currently over 50 years of age? If not, you are not eligible for the Community Adult Hearing service and should make an appointment with your GP Practice.

**About your hearing problem**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Have you noticed any problems with your hearing? | o | o |
| If yes, are you concerned or worried about your hearing difficulties? | o | o |
| If yes, would you be prepared to consider using hearing aids? | o | o |

If you answer **YES** to any of the questions below, you will not be eligible for the Community Adult Hearing service and should make an appointment with your GP Practice.

|  |  |  |
| --- | --- | --- |
| **Have you experienced:** | **Yes** | **No** |
| Persistent pain affecting either ear lasting more than seven days within the last 90 days? | o | o |
| Any discharge from either ear within the last 90 days other than wax? | o | o |
| Sudden (within seven days) loss or deterioration of hearing not associated with a cold or upper respiratory tract infection. If so, seek medical advice. | o | o |
| Rapid (within 90 days) loss or deterioration of hearing? | o | o |
| Fluctuating hearing loss, other than associated with colds? | o | o |
| History of surgery on the ears other than grommets (unless grommets inserted in the past 12 months?) | o | o |
| Vertigo (nausea, swaying or floating sensations) within the last 90 days? | o | o |
| Tinnitus (e.g. internal sounds in the ear) in one or both ears lasting for more than five minutes at a time, or that is in time with your heartbeat/pulse, or that is severe enough to disturb your sleep. | o | o |
| Have you had NHS hearing aids supplied in the last three years? (If yes, please contact your previous provider) | o | o |
| Please provide details of any relevant medical information and any other considerations (such as any ear operations, a learning disability, mobility or language needs): | | |

**If a provider has assisted you with completion of the form and you have answered ‘yes’ to any of the above questions, you will not meet the criteria for self-referral.**

The provider will direct you on next steps and, if necessary, report this to your practice (including speaking to the practice to hand over details if urgent) and the reasons for not meeting the criteria. Please also contact your GP practice within approximately two weeks to discuss.

**If you think that you have ear wax, please discuss this with your provider of choice.** Wax must be dealt with first, as it can sometimes mean a hearing assessment cannot take place, although not always, or the hearing aids cannot be fitted.

**If you have selected 'No' in response to all the questions above:**

Thank you for completing the form. Your answers have shown that you are eligible to self-refer to the local audiology service. **Please now get in touch with your provider of choice via telephone, or online to arrange next steps. You can access a list of providers below.** **No further action will be taken unless you contact your provider of choice.**

Please note, should you undergo a hearing test receive a hearing aid(s), the provider will manage your aftercare and review appointments for a period of three years. Typically, at the end of this period, you may be offered a full reassessment and be given the option to choose a provider. Your current provider will assist you with this process.

Please complete the following questions to tell us more about you, so we can understand your needs better.

**About you:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NHS Number:** |  | **Age:** | **Date of Birth:** |
| **Surname:** |  | **Title:** |  |
| **Forenames:** |  | | |
| **Address:** | | | |
| **Postcode:** |  | **Email Address:** |  |
| **Preferred Tel No:** |  | **Mobile Tel No:** |  |
| **Ethnic Origin:** |  | | |
| **GP Surgery Name and Address:** |  | | |

***Thank you for taking the time to complete this form, please keep it and show it to the relevant provider if needed.***