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| **In Health** | **NHS** |

**SOUTHAMPTON CITY AUDIOLOGY SELF-REFERRAL FORM**

**Please note – we are unable to accept referrals for patients under 16 years of age.**

**This self-referral form is for SOUTHAMPTON CITY CCG patients only. If you are unsure which CCG you belong to please enter your GP details into** [**https://mapit.mysociety.org/**](https://mapit.mysociety.org/) **and check the “Clinical Commissioning Group” field**

**Please ensure all fields with a \* are filled in accurately**

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| **PATIENT** | | **GP DETAILS** | | | |
| NHS Number (if known) |  | \*Name |  | | |
| \*Forename |  |  |  | | |
| \*Surname |  | \*Address |  | | |
| \*Address |  |  |  | | |
| \*Date of Birth |  |  |  | | |
| \*Telephone (Home) |  |  |  | | |
| Telephone (Work) |  | Telephone No. |  | | |
| Telephone (Mobile) |  |  |  | | |
| E-mail Address |  |  |  | | |
| Gender | Male  Female |  | | | |
| Physical/Communication difficulties (specify if any): | | Wheelchair user? Yes | | | |
| If interpreter required, language: | |  | | | |
| Ethnicity | |  | | | |
| **REASON FOR REFERRAL:**  Please provide as much relevant information as possible:    Date of referral | | | | | |
| **Please ensure your ears are free from wax prior to attending a hearing assessment.** | | | | | |
| Have you previously been fitted with a hearing aid?  Date of last hearing assessment (if known) | | | | | Yes No |
| **Please e-mail this form to the InHealth Patient Referral Centre:**  **Sandbrook House, Sandbrook Way, Rochdale OL11 1RY**  **Tel: 0333 202 0297 E-mail: inl.inhealthreferrals@nhs.net** | | | | **www.inhealthgroup.com**  **Version001: Feb 2021** | |