**Paediatric Community Audiology Referral Form**

**Integrated services for Children with Additional Needs (ICAN)**

**Thank you for completing all sections of the referral form.**

**Incomplete referrals may be returned.**

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| **CHILD/YOUNG PERSON DETAILS** | | | | |
| **Name of child/young person** | | | **Is an Interpreter Required?**  **Yes □**  **No □**  **If Yes - Please state language required** | |
| **Date of Birth** | **NHS Number** | |
| **Age of child/young person** | **Male/Female** | | **School/Nursery/Children’s Centre Details** | |
| **Address** | | |
| **Postcode** | | | **GP/Family Doctor Name and Contact Number** | |
| **Telephone Number** | | | **Health Visitor/School Nurse Name and Contact Number** | |
| **Mobile Telephone Number** | | | **Any Other Professionals Names and Contact Numbers** | |
| **Email address** | | |  | |
| **Parent/Carer Consent obtained this referral?**  **Yes □**  **No □** | | | **Self-Consent obtained for this referral?**  **Yes □**  **No □** | |
| **Will the family have difficulty contacting us to choose and book an appointment?**  **Yes □**  **No □** | | | **How does the family prefer to be contacted?**  **□ Telephone**  **□ Letter** | |
| **Are there any Safeguarding Concerns regarding this child/family?**  **Yes □**  **No □** | | | **Parent/Carer Consent to receive text reminder message**  **Yes □**  **No □** | |
| **Height** | | **Centile** | **Weight** | **Centile** |
| **REFERRING CLINICAL PRACTITIONER DETAILS** | | | | |
| **Name of person completing this form ►** | | |  | |
| **Title of referrer** | | |  | |
| **Address** | | |  | |
| **Telephone Number / Email address** | | |  | |
| **Date of referral** | | |  | |

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| **Referral Reason** | |
| **Does the child have any of the following? Please tick** | |
| **Family History of Deafness □**  **Speech & Language Delay □**  **Behavioural Problem □**  **Complex Needs □**  **Learning Difficulties □** | **Parental Concern about Hearing □**  **Professional Concern about □**  **(e.g. teacher/health visitor)**  **Frequent Ear Infections □**  **Medical Condition □**  **Other □** |
| **The completed referral should be sent to ICAN Services by one of the following methods:** | |
| **By SystmOne task once referral has been added to communications and letters, ideally using the ICAN referral form template:**  **To sys1 unit “Leeds Community Child Health Services”, task group “Central Referral Management Tm”, task type - ideally with some reference that a referral is being made**  **PLEASE DO NOT SEND E-REFERRALS TO THE CHILD HEALTH UNIT DIRECTLY** | |
| **By email: ican.referrals@nhs.net** | |
| **By Post:**  **The Referral Management Centre**  **Integrated services for Children with Additional Needs**  **3rd Floor Stockdale House**  **Victoria Road**  **Leeds**  **LS6 1PF** | |
| **Telephone enquiries to: 0113 843 3689** | |