WYEOUTPATIENTS

NHS

ENT Referral Form: Paediatric ENT + Audiogram

Part 1: Paediatric ENT Referral

PLEASE NOTE: All Paediatric ENT referrals also need an audiogram.
By completing Part 2 of this document you will also be requesting a separate referral for an audiogram at Wye Surgery. If this is not what you want, please either use a different referral form or attach a recent audiogram result and discard Part 2 of this form.

EXCLUSIONS
This clinic DOES NOT accept referrals for:

- Rapid Access patients
- Patients aged 18 or over

PATIENT DETAILS

NHS Number _____

First name _____

Last name _____

Address _____

_____

Postcode _____

Mobile phone _____

Other phone _____

Date of birth _____ / _____ / _____

REFERRING CLINICIAN DETAILS

Practice G8 ref _____

First name _____

Last name _____

Address _____

_____

Postcode _____

Phone number _____

Fax number _____

Signed _____

Dated _____

REFERRAL TYPE & DETAILS

Details of presenting condition + relevant medical history (including previous + current treatment + medications):

_____

_____

Email your referral to: kmccg.wyesurgeryclinics@nhs.net
Alternatively fax or post to: Outpatients Clinic, Wye Surgery, Oxenturn Rd, Wye, Kent TN25 5AY.
Tel: 01233 884 585 Ext 2222

IF YOU WISH, PLEASE COMPLETE AUDIOGRAM REFERRAL OVERLEAF >

WYEOUTPATIENTS

NHS

ENT Referral Form: Paediatric ENT + Audiogram

Part 2: Paediatric Audiogram Referral

EXCLUSIONS - for this separate paediatric audiogram referral

- Rapid Access Patients
- Patients over 18
- Non-wax ear discharge within 3 months prior to appointment:
- Sudden hearing loss (requires immediate ENT opinion)
- Otalgia > 7 days within 3 months prior to appointment
- Tinnitus and vertigo
- If hearing aid has been fitted during last 12 months
- Noise-induced hearing loss, patient must be away from the source for 24 hours before appointment

PATIENT DETAILS

NHS Number _____

First name _____

Last name _____

Address _____

_____

_____

Postcode _____

Phone number _____

Date of birth _____

Domiciliary visit needed (based on clinical need)?

☐ YES ☐ NO

Please give details of relevant medical history (including previous and current treatment and medications):

_____

_____

_____

_____

_____

_____

_____

REFERRING CLINICIAN DETAILS

Practice G8 ref _____

First name _____

Last name _____

Address _____

_____

_____

Postcode _____

Phone number _____

Fax number _____

ONLY - Wax-free ears please!

Ears must be free from occluding wax or the patient cannot be seen.

Are your patient's ears wax-free? ☐ YES ☐ NO*

***If No, please do not refer to this clinic**, yet.

Signed _____

Dated _____

Email this referral to:
kmccg.wyesurgeryclinics@nhs.net

Alternatively fax or post to: Outpatient Clinics,
Wye Surgery, Oxenturn Rd, Wye, Kent TN25 5AY
Tel: 01233 884 585 Ext 2222

PLEASE SUBMIT BOTH PARTS OF THIS COMPLETED REFERRAL FORM