AQP Direct Access Hearing Loss Self Referral Form

Adult Related Hearing Loss Service

Please complete all fields below in order that your chosen provider can give you a hearing assessment (if appropriate).

Data Protection – The information provided in this form will be used for the purpose of assessing the right care for you, and will also form part of your clinical care record which will be kept in line with the Data Protection Act.

Patient Details:	
Customer Reference Number:	
GP Surgery Address:	
NHS Number:	Date of Birth: Age:
Surname:	Title:
Forenames:	
Address:	
Postcode:	Email Address:
Preferred Tel No:	Mobile Tel No:
Ethnic Origin:	

Have you experienced:	Yes	No	N/A
Have you noticed any problems with your hearing?	☐	☐	
If yes, are you concerned or worried about your hearing difficulties?	☐	☐	☐
If yes, would you be prepared to consider using hearing aids?	☐	☐	☐
Have you had NHS hearing aids fitted before?	☐	☐	

If yes, when did you last receive NHS hearing aids and from whom

_____

If you answer yes to any of the questions below, you will not be eligible for the Direct Access Adult Hearing service and should make an appointment with your GP.

Have you experienced:	Yes	No
Persistent pain affecting either ear lasting more than 7 days?	☐	☐
Any discharge other than wax?	☐	☐
Sudden and/or Rapid loss or deterioration of hearing?	☐	☐
Fluctuating hearing loss?	☐	☐
Any nausea, swaying or floating sensations (vertigo)?	☐	☐
Tinnitus (e.g. unilateral, recent onset, severe enough to disturb sleep)?	☐	☐

Please provide details of your relevant Past Medical History and Other considerations (such as any ear operations, a learning disability, mobility or language needs):

Please sign to confirm that you have answered this questionnaire truthfully and accurately to the best of your knowledge.

Name:_____ Date:_____ Signed:_____