|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Questions are followed by answer fields. Use the ‘Tab’ key to navigate through. Replace Y/N or Yes/No fields with your answer. | | | | | | | | | | | | |
| Before you fill in the form Use this form to refer clients to NT Hearing Services. The information provided to NT Hearing Services will be used, disclosed and stored for the purpose of hearing assessment and referral and will be managed in accordance with the privacy provisions of the *Information Act 2002* and Information Privacy Principles.  This form can be self-completed or completed by any professional, parent or carer to refer for a hearing test, however if referral to an ENT/Teleotology is required a medical practitioner must complete section 3.  NT Hearing Services do not provide:   * hearing aid fitting * repair services * hearing assessments for work or compensation reasons.   Contact NT Hearing Services on 8922 7110 if alternative contact details are needed for these services.  Submit this form to [nthearing.darwin@nt.gov.au](mailto:nthearing.darwin@nt.gov.au) | | | | | | | | | | | | | |
| Client details (the client you’re referring to the service) | | | | | | | | | | | | | |
| Surname | | |  | | | | Given name | |  | | | | |
| Date of birth | | |  | | | | Age | |  | | | | |
| Is the child of Aboriginal or Torres Strait Islander origin? | | | Aboriginal / Torres Strait Islander | | | | Name of school, preschool or childcare | |  | | | | |
| Residential address | | |  | | | | Postal address | |  | | | | |
| HRN | | |  | | | | Previous client of hearing service? | | Y / N | | | | |
| Parent / Caregiver details | | | | | | | | | | | | | |
| Surname | | |  | | | | Given name | |  | | | | |
| Residential address (if different from above) | | |  | | | | Postal address (if different from above) | |  | | | | |
| Preferred contact number | | |  | | | | Alternative contact number | |  | | | | |
| Email | | |  | | | | Relationship to child | |  | | | | |
| Parent/caregiver approval for referral? | | | Y / N | | | | | | | | | | |
| Person referring | | | | | | | | | | | | | |
| Surname | | |  | | | | | First name | |  | | | |
| Relationship or role with client | | |  | | | | | Clinic or Department phone number | |  | | | |
| Email | | |  | | | | | Phone | |  | | | |
| Signature | | |  | | | | | Date | |  | | | |
| Section 1 – Complete for all clients | | | | | | | | | | | | | |
| Please describe in detail the main concerns for the client | | | |  | | | | | | | | | |
| Allergies and alerts | | | |  | | | | | | | | | |
| Detail on all diagnosed medical and physical conditions | | | |  | | | | | | | | | |
| If the client has no diagnosis but is currently being investigated for any health, developmental or behavioural conditions (developmental delays, autism), please provide detail | | | |  | | | | | | | | | |
| Does the client show any unusual behaviours (e.g. tantrums, head banging, obsessive and repetitive behaviours, attention difficulties)? | | | |  | | | | | | | | | |
| Is the client currently seeing or on a waiting list for any other allied health or medical specialists (e.g. Psychologist, Neurologist, Speech Pathologist, Occupational Therapist or Physiotherapist)? | | | |  | | | | | | | | | |
| Section 2 – Referral to an ear, nose and throat specialist  All of the conditions in the table below will require a hearing (audiology) assessment and referral to an Ear, Nose and Throat specialist. This referral will be accepted for audiology only unless section 3 is completed by a medical practitioner. Attach any relevant medical history. | | | | | | | | | | | | | |
| Persistent Otitis Media with Effusion (OME/glue ear) >3 months with documented hearing loss >25dB | | | | | | | | | | | | | Y / N |
| Recurrent ear infections (3 episodes in 6 months or 4 episodes in 12 months) | | | | | | | | | | | | | Y / N |
| CSOM (Chronic Suppurative Otitis Media) >3 months | | | | | | | | | | | | | Y / N |
| Dry perforation >3 months | | | | | | | | | | | | | Y / N |
| Complicated ear conditions, cholesteatoma, unsafe/urgent ear conditions | | | | | | | | | | | | | Y / N |
| Other, provide details | | |  | | | | | | | | | | |
| Section 3 – Medical practitioners only to complete | | | | | | | | | | | | | |
| Are you requesting audiology? | | | | | | | | | | | | | Y / N |
| If yes, an age and developmentally appropriate hearing test will be provided.  Hearing testing can sometimes identify reasons for the client to be referred for further management by an Ear, Nose and Throat specialist.  Do you authorise NT Hearing Services to forward this referral to an ENT Specialist of the patient’s choice should audiological assessment indicate this is required? | | | | | | | | | | | | | Y / N |
| Are you requesting ENT/teleotology (as per CARPA guidelines) | | | | | | | | | | | | | Y / N |
| If yes, has a separate referral to ENT already been sent? | | | | | Y / N | What date was the referral sent? | | | | | |  | |
| Name | |  | | | | Signature | | | | |  | | |
| Provider number | |  | | | | Clinic address | | | | |  | | |
| Clinic email | |  | | | | Clinic phone | | | | |  | | |
| Date | |  | | | | Preferred ENT | | | | |  | | |
| Further information Acknowledgement of referral will be sent via email once received by NT Hearing Services if valid email address provided. Please call NT Hearing Services on 8922 7110 or email on [nthearing.darwin@nt.gov.au](mailto:nthearing.darwin@nt.gov.au) for queries on the progress of a referral. | | | | | | | | | | | | | |
| End of form | | | | | | | | | | | | | |