Queensland Government

Children's Health Queensland Hospital and Health Service

Queensland Hearing Loss Family Support Service

Referral

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Please use this form for children who have NOT been referred via the Healthy Hearing Newborn Screening Program to the Queensland Hearing Loss Family Support Service. This will include children with:

1. Permanent hearing loss identified through the Healthy Hearing Targeted Surveillance program
2. A diagnosis of 'later onset' or acquired permanent hearing loss

NAME OF REFERRER:

☐ Audiology ☐ Paed/ENT ☐ EQ AVT ☐ GP ☐ Other:

Referrer address:

Referrer phone: **Email:**

Audiologist and clinic attending (if different from referrer):

Child's full name: **Child's DOB:**

Mother's name: **Phone:**

Father's name: **Phone:**

Address:

✶ Please attach audiology report, previous referral information, and any other relevant documentation ✶

HEARING INFORMATION

*Reason for original referral to referrer, dates of assessment, **type / degree of hearing loss**, medical / developmental issues e.g. syndromes, pregnancy and birth complications, aetiology, family history of HL*

PSYCHOSOCIAL FACTORS

Family history, relationships, medical, mental health, financial / housing, support, other current stressors

Is the family aware of the referral **AND** have they given consent for QHLFSS contact? ☐ Yes ☐ No

NON HEALTHY HEARING CHILDREN ONLY: Consent to Healthy Hearing Data Collection (Qchild)? ☐ Yes ☐ No

Please email or fax the completed referral form to:

Brisbane
Ph: (07) 3310 7809
Fax: **(07) 3310 7808**

Townsville
Ph: 1800 352 075
Fax: **(07) 4724 1480**

Email: **QHLFSS@health.qld.gov.au**

Referrer's signature:

Date:

DO NOT WRITE IN THIS BINDING MARGIN

QHLFSS REFERRAL

v1.00 - 07/2016