Women's and Children's Health Network

Child and Family Health Service

REFERRAL FOR FULL DIAGNOSTIC AUDIOLOGICAL ASSESSMENT

CLIENT LABEL

ID Number: .....

Surname: .....

Given Names: .....

D.O.B: ..... Sex: .....

Birthing hospital: .....

If the baby transferred hospital, where was the screen performed: .....

BABY'S DETAILS

Baby's Surname: ..... Given Name/S: .....

DOB: ...../...../..... Ur No: .....

Gestational Age: ..... Term Date: ..... Indigenous Status: .....

Mother's Family Name: ..... First Name: .....

Postal Address: ..... Postcode: .....

Mobile Number: ..... Interpreter Required: ☐ Yes ☐ No Language: .....

NOTIFICATION OF INFANT REQUIRING FULL AUDIOLOGICAL ASSESSMENT

☐ Cranio-facial abnormalities that might imply abnormal anatomy of the central neurological pathways or auditory pathway:
☐ Hydrocephalus ☐ Microcephaly ☐ Cleft Palate ☐ Other: .....

☐ Conditions that necessarily impede hearing e.g. atresia of the external auditory meatus

☐ Any Syndrome related to a permanent hearing loss, e.g. Pendreds, Waardenburg

☐ Bacterial or viral meningitis

☐ Significant congenital infection in baby (TORCH) including:
☐ Toxoplasmosis ☐ Rubella ☐ CMV ☐ Herpes Simplex ☐ Syphilis infection

RISK FACTORS TO BE FOLLOWED UP AT 12 MONTHS OF AGE IN HAS – Please send in referral

☐ Immediate family history of permanent hearing loss (Parents, siblings, child's parent's sisters/brothers or their children)

☐ Head trauma that requires hospitalisation or disorder affecting the brain or nerve pathways

☐ Any syndrome where the child is prone to developing middle ear pathology e.g. Down Syndrome

☐ NICU Admission >5 days

☐ Assisted ventilation

☐ Hyperbilirubinaemia requiring exchange transfusion

☐ Exposure to ototoxic medications such as Aminoglycosides antibiotics (e.g. Gentamicin) or loop diuretics administered for 3 days or more at the time of screening

DISCHARGE PLAN

☐ Infant has been discharged home .....

☐ Infant expected to remain as an inpatient in Ward: .....

Hospital: ..... Until approx: ...../...../.....

☐ Infant is expected to remain a long stay inpatient in Ward: ..... Hospital: .....

Completed by

Staff name: ..... Designation: .....

Signature: ..... Date: ...../...../..... Hospital: .....

FAX TO UNHS ON 8303 1640

Please call 8303 1585 if you have any questions.

LEGEND:

DOB = Date of Birth
TORCH = Toxoplasmosis Other Rubella Cytomegalovirus Herpes
CMV = Cytomegalovirus
NICU = Neonatal Intensive Care Unit
SBR = Serum bilirubin levels
Rh = Rhesus
UNHS = Universal Neonatal Hearing Service
UR = Unit number
ID = Identification

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