OneWelbeck
Ear, Nose & Throat

OneWelbeck ENT Audiology Referral Form

Please complete all sections of the form and return to **bookings.ent@onewelbeck.com**.

PATIENT DETAILS

TITLE: FORENAME(S): SURNAME:

DATE OF BIRTH: GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

RESIDENTIAL ADDRESS: POSTCODE:

TELEPHONE: MOBILE:

EMAIL:

REFERRAL DETAIL

☐ Pure Tone Audiometry
☐ Tympanometry (as sole procedure)
☐ Tympanometry (including stapedial reflexes)
☐ Speech audiometry
☐ Otoacoustic emissions
☐ Earwax / foreign body removal (microsuction)
☐ Hearing aid consultation
☐ Auditory implant assessment (BCD / MEI / CI)
☐ Cochlear implant programming – unilateral
☐ Cochlear implant programming - bilateral
☐ Vestibular rehabilitation
☐ Tinnitus therapy
☐ Auditory Processing Disorder (APD) assessment
☐ Other (please specify)……………..

REFERRER DETAILS

GP/REFERRER NAME: GP/REFERRER PRACTICE:

GP/REFERRER CONTACT NUMBER: GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

TYPE: ☐ Self-funding ; ☐ Insured ; ☐ Embassy ; ☐ Other (please complete below sections as appropriate)

INSURER:
AUTHORISATION CODE: MEMBERSHIP NO:

EMBASSY: LETTER OF GUARANTEE: ☐ Yes (please attach)

EXTRA REQUIREMENTS

SPECIAL EQUIPMENT REQUIREMENTS: WHEELCHAIR ACCESS: ☐

INTERPRETER REQUIRED: ☐ Yes, please confirm language:

OTHER:

DECLARATION

NAME: SIGNED: DATE:

By completing this form, you confirm you have the consent required to share this information.

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

E: bookings.ent@onewelbeck.com
A: OneWelbeck ENT, 1 Welbeck Street London W1G 0AR
T: +44 (0)203 653 2007