**Southern Cochlear Implant Programme**

**Paediatric Referral Form (0 – 19 years)**

The child’s parent/caregiver has given verbal consent for this referral and for SCIP to access medical and education information relevant to cochlear implant assessment **(*Ensure box is ticked before proceeding*)**

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| **Please complete referrer details:** | |
| Date of referral: |  |
| Referrer’s Name & Title: |  |
| Clinic Address: |  |
| Clinic Phone: |  |
| Contact email: |  |

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| **Referral Criteria** | **Information Required** |
| **NZ Permanent Residency**  Patients will not be able to access services in the publicly funded service if they do not hold NZ Permanent Residency. | Copy of patient’s birth certificate, citizenship certificate, or Permanent Residency visa. |
| **Baseline Audiometric Criteria**   * Children with a bilateral severe hearing loss or worse, from 1 kHz to 8 kHz on ABR testing or on an unaided test. * Children with limited aided speech information above 2 kHz (as seen on speech-mapping). Children with a severe reverse sloping hearing loss or worse whose speech and language is not progressing adequately. * Children with auditory neuropathy spectrum disorder who are not progressing in their speech and language development. * Children who have recently suffered from meningitis which has caused a sensorineural hearing loss should be referred urgently upon diagnosis. A CT/MRI to be arranged through the local ENT service. * Children referred who are older than three years of age should have documented evidence of oral language developing. * Children who are over four years of age with no oral language will be considered and discussed only on a case-by-case basis. * A child older than five years of age with no language is unlikely to benefit from a cochlear implant. * Children with additional needs will be accepted for assessment | Please attach all of the following audiological information:   * ABR result summary if available * Diagnostic audiogram (speech audiometry, immittance audiometry, OAEs, aided testing) * Previous audiograms & speech audiometry * Copies of any ENT and Paediatrician reports and letters. |
| **Hearing Aids**  The patient should be optimally aided. | Please enclose:   * Real ear measures |

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| **Please complete all patient details:** | |
| Client Name: |  |
| Client Address: |  |
| Date of Birth: |  |
| Name and address of General Practitioner: |  |
| Name of Advisor on Deaf Children (if applicable): |  |
| Age hearing loss confirmed: |  |
| Date hearing aids first fitted: |  |
| Make and Model of current Hearing Aids and Date Fitted: |  |
| Earmould Type and Date Fitted: |  |
| Cause of hearing loss: e.g. meningitis, Connexin mutation, EVAS, CMV, other. |  |
| Additional diagnoses: e.g. syndromes, global developmental delay, vision |  |
| Brief description of hearing history and functional hearing: Click here to enter text. | |

**Please ensure copies of the following are enclosed:**

Please email documents to [**reception@scip.co.nz**](mailto:reception@scip.co.nz) or post to

*Clinical Co-ordinator*

*Southern Cochlear Implant Programme*

*Milford Chambers*

*St George’s Hospital*

*249 Papanui Rd*

*Christchurch 8014*

Proof of New Zealand Permanent Residency

All available audiograms

Copy of most recent real ear measures

ENT and Paediatrican reports and letters (if available)