**Southern Cochlear Implant Programme**

**Referral Form for Adults (≥ 19 years)**

The patient has given verbal consent for this referral, and for SCIP to access medical 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**  Hearing loss should be severe from 1 kHz to 8 kHz on unaided testing and/or have limited access to speech information above 2 kHz (as seen on speech mapping), or have a diagnosis of Auditory Neuropathy Spectrum Disorder  They must previously have had sufficient hearing to have developed spoken language.  Speech audiometry less than 60% on HINT sentence or less than 30% on CNC words | Please attach all the following audiological information:   * Current diagnostic audiogram (speech audiometry, immittance) * Previous audiograms and speech audiometry * Copy of any ENT reports (if available) |
| **Hearing Aids**  The adult client should be optimally aided. They should have ear moulds fitted in the last year. | 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: |  |
| Age hearing loss confirmed: |  |
| Duration of Hearing Loss: |  |
| Duration hearing loss has been severe/profound: |  |
| Duration loss has been aided: |  |
| Cause of hearing loss: e.g. meningitis, congenital, progressive, other |  |
| Primary Mode of Communication: |  |
| Make and Model of Current Hearing Aids and Date Fitted: |  |
| Earmould Type and Date Fitted: |  |
| Brief description of hearing history: 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 reports and letters (if available)