**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.
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| **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** 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)