**Southern Cochlear Implant Programme**

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

**☐** The client 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*)**

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

|  |  |
| --- | --- |
| **Referral Criteria** | **Information Required** |
| **NZ Permanent Residency**Adults will not be able to access services in the publicly funded programme if they are not either citizens or permanent residents.  | Copy of client’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 DisorderUnaided speech testing scores (AB Words, CVC Words) poorer than expected based on pure tone audiogramThe client must previously have had sufficient hearing to have developed spoken language.  | 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
 |

|  |
| --- |
| **Please complete all client 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 | Click here to enter text. |
| 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** 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)