**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*)**

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| **Please complete referrer details:** | |
| Date of referral: | Click here to enter text. |
| Referrer’s Name & Title: | Click here to enter text. |
| Clinic Address: | Click here to enter text. |
| Clinic Phone: | Click here to enter text. |
| Contact email: | Click here to enter text. |

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| **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 Disorder  OR unaided speech testing scores (AB Words, CVC Words) poorer than expected based on pure tone audiogram  The 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 |

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| **Please complete all client details:** | |
| Client Name: | Click here to enter text. |
| Client Address: | Click here to enter text. |
| Date of Birth: | Click here to enter text. |
| Client phone number (landline and mobile): | Click here to enter text. |
| Client email address: | Click here to enter text. |
| Name and address of General Practitioner: | Click here to enter text. |
| Age hearing loss confirmed: | Click here to enter text. |
| Duration of Hearing Loss: | Click here to enter text. |
| Duration hearing loss has been severe/profound: | Click here to enter text. |
| Duration loss has been aided: | Click here to enter text. |
| Cause of hearing loss: e.g. meningitis, congenital, progressive, other | Click here to enter text. |
| Primary Mode of Communication: | Click here to enter text. |
| Make and Model of Current Hearing Aids and Date Fitted: | Click here to enter text. |
| Earmould Type and Date Fitted: | Click here to enter text. |
| 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)