**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*)**

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

|  |  |
| --- | --- |
| **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 |

|  |  |
| --- | --- |
| **Please complete all patient details** | |
| **Client Name** |  |
| **Client Address** |  |
| **Date of Birth** |  |
| **Parent/caregiver name and contact details**  **Email:**  **Phone:** |  |
| **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: eg. meningitis, Connexin mutation, EVAS, CMV, other** |  |
| **Additional diagnoses: eg. 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)

**Privacy Statement**

**SCIP will manage your health information in accordance with our Privacy Statement, which explains what information we collect, why we need it, how we will use it and who we might need to share it with. If you have any concerns about providing us with information, or authorising us to collect information from third parties, talk to us about it and we can help you understand why we need it. Please refer to our website for our full Privacy Statement.** [**www.scip.co.nz**](http://www.scip.co.nz)