

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 educational information relevant to cochlear implant assessment
(ensure this box is ticked before proceeding)

Referrer Details	
Date of Referral	
Referrer's name and title	
Clinic address	
Clinic phone	
Contact email	

Referral Criteria	Information Required
<p>NZ Residency To be eligible for a cochlear implant, you must live permanently in New Zealand.</p>	Copy of client's birth certificate, evidence of citizenship or a residence class visa
<p>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.</p> <p>Children with limited aided speech information above 2 kHz (as seen on speech-mapping). Children with severe reverse sloping hearing loss or worse whose speech and language is not progressing adequately.</p> <p>Children with auditory neuropathy spectrum disorder who are not progressing in their speech and language development.</p> <p>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</p>	Please attach all the following audiological information: <ul style="list-style-type: none"> • 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.

<p>the local ENT service.</p> <p>Children referred who are older than three years of age should have documented evidence of oral language developing.</p> <p>Children who are over four years of age with no oral language will be considered and discussed only on a case-by-case basis.</p> <p>A child older than five years of age with no language is unlikely to benefit from a cochlear implant.</p> <p>Children with additional needs will be accepted for assessment</p>	
<p>Hearing Aids The patient should be optimally aided.</p>	<p>Please enclose - Real ear measures</p>

Please complete all client details	
Client Name	
Client Address	
Date of Birth	
Parent/caregiver name and contact details (phone number and email address)	
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 diagnosis: eg. syndromes, global development delay, vision	
Brief description of hearing history and functional hearing	

Please ensure copies of the following are enclosed:

- Proof of New Zealand Residency
- All available audiograms
- Copy of most recent real ear measures
- ENT and Paediatrician reports and letters
(if available)

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 Road
Christchurch 8014

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