

Please complete the following Self-Referral questionnaire

Surname	
Forename	
Gender	
Date of birth	
Age (In years)	
NHS no. (If available)	
Your full address (including post code)	
Home telephone no.	
Mobile telephone no.	
Work telephone no.	
Email address	

Name of your GP	
Address of your GP (Inc. Postcode)	
Telephone no. of GP	

Fluent in English? Or please state preferred language.	
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Do you have any short term memory problems? (Yes or No)	
Have you good dexterity in your hands, arms and shoulders? (Yes or No)	
Do you have any visual impairment (other than wearing reading glasses)? (Yes or No)	

Do you require ambulance transport? And/or do you require wheelchair access? Is there any other relevant information you wish to share with us?

I understand in submitting this form that I consent to share my personal details with the Hearing Services Department, UHL.

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Please complete the following Self-Referral questionnaire

- Your ears have been checked and are clear of all wax
- Both your ear drums are intact
- You do not report fluctuating hearing loss, ear pain longer than 7 days or discharge within 90 days
- You do not report unilateral hearing loss and/or unilateral or troublesome tinnitus or tinnitus which is pulsatile in nature.
- You do not report suffering with dizziness (vertigo)

I wish to have my hearing assessed and if needed, I would like to be considered for NHS hearing aids.

I confirm that I do not have any of the symptoms listed above and I understand that should any of these be identified at my assessment, the Audiologist will refer me to my GP for further advice and/or onward referral.

Signed: **Dated:**.....

Please return the completed form to: hearingservices@uhl-tr.nhs.uk

Or post to:

Self-referrals

Hearing Services Department

Leicester Royal Infirmary

Leicester

LE1 5WW