

**Hearing Support Team**

**Referral Form**

**Please note: We accept referrals for children and young people who have a diagnosed hearing loss and have been prescribed hearing aid(s) or cochlear implants. For more details see our Local Offer pages:** [Sensory Support Hearing | Local Offer Birmingham](https://www.localofferbirmingham.co.uk/send_support_services_menu/sensory-support-hearing/)

**Please return the completed form, parental consent form and any hospital reports Hearing Support Team using the email address below, adding New Referral in the subject line. Thank you**

[**HSTreferrals@birmingham.gov.uk**](mailto:HSTreferrals@birmingham.gov.uk)

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| **Personal Details of Pupil** | | | |
| Forename: | Surname: | | Preferred name: |
| Date of Birth: | | Gender: | |
| Age: | | Preferred language: | |
| Year Group: | | Nursery Children Only  Attends: a.m. / p.m. / full time | |
| Child Protection Plan : Y/N  Child in Need Plan Y/N  Looked after child Y/N | | EHC Plan: Y/N  SSPP Plan Y/N  EY Plan Y/N | |

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| **Parents/Carers details** | | | | | | |
| Forename: | | | Surname: | | | |
| Forename: | | | Surname: | | | |
| Home Address:  Postcode**:** | | | | | | |
| Tel No: | | Relationship to Child: | | | Parental responsibility: Yes | |
| Email: | | | | | | |
| **Communication with the child and family** | | | | | | |
| Child’s first language |  | | | Language used within the home | |  |
| Is an interpreter required for parents? | Yes  No | | | If so, which language? | |  |

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| **Placement Details** | | | | | | | | | | | |
| School/Setting: | Tel No: | | | | | | Address: | | | | |
| SENCO Name: | SENCO Email: | | | | | | | | | | |
| SENCO working days | Mon | | Tues | | Wed | | | Thurs | | Fri | |
| am | pm | am | pm | am | pm | | am | pm | am | pm |

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| **Referral Information** | | | | |
| Details of hearing loss, including:   * Unilateral or Bilateral hearing loss (affecting only one or both ears) * Degree of hearing loss (mild, moderate, severe or profound) * Impact on communication and access to learning | | | | |
| Type of hearing aids prescribed (hearing aids, cochlear implants, bone conduction aid – can be worn on a soft or a hard band or permanently fixed) | | | | |
| Name of the child’s audiology clinic (City Hospital, B’ham Children’s or Heartlands) | | | | |
| Any Additional Needs (e.g. SEN and medical including allergies) | | | | |
| Please give details of all other educational agencies involved (e.g. E.P., PSS, CAT) | | | | |
| Name | | Agency | | Contact Details |
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| Please give details of all medical agencies involved (e.g. Hospital Consultant, Physiotherapist, Occupational Therapist) | | | | |
| Name | Agency | | Contact Details | |
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| **Referrers Details** | |
| Name of Referrer: | Role: |
| Contact details: | |
| Signature: | Date: |