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**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**

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

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| 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:       |