



Northern
Cochlear Implant
Programme

Paediatric cochlear implant referral form (0 to 19 years)

To ensure your referral is accepted and actioned immediately, it is vital that we receive the complete information requested below.

New Zealand residency - Patients will not be able to access services in the publicly funded programme if they do not hold New Zealand residency or citizenship.

REFERRER DETAILS

Name and title:

Work address:

Referral date:

Work Phone:

Email:

CLIENT DETAILS

Name:

NHI:

Date of birth:

Parent/caregiver name:

Parent/caregiver phone number:

Parent/caregiver Address:

Age hearing loss confirmed:

Date hearing aids fitted:

Cause of hearing loss:

INFORMATION REQUIRED

Please ensure you have completed everything on the following checklist:

Investigations completed to date:

If no investigations completed, please provide date of ENT referral:

Has the AODC service been contacted? ☐ Yes ☐ No

Who is the AODC working with the family?

Apart from AODC services, are there any other services or agencies involved with the patient?

Please comment on: attendance, hearing aid usage, any other relevant information not covered above.

PLEASE ENSURE YOU HAVE COMPLETED AND ATTACHED EVERYTHING LISTED BELOW (IF APPROPRIATE)

☐ Completed all of the referrer details section ☐ Completed all of the client details section

Please ensure copies are enclosed of:

- ☐ ABR (if available)
- ☐ Current diagnostic audiogram (speech audiometry, immittance audiometry, and otoacoustic emissions)
- ☐ Previous audiograms and speech audiometry
- ☐ Copy of hearing aid settings
- ☐ Copy of real ear measures
- ☐ Separate ear aided testing carried out at 60dB SPL (45dB HL) using the appropriate SPANZ speech test (if other presentation level, please state)

**Please email documents to clinicalservices@hearinghouse.co.nz or send via post to:
The Hearing House, PO Box 74022, Market Road, Auckland 1543.**