NORTH TYNESIDE SENSORY SERVICE AT BEACON HILL

Referral to Sensory Team – Hearing Impairment

SCHOOL _____

CHILD'S NAME _____ D.O.B _____

ADDRESS _____

_____

_____

POSTCODE _____

EMAIL

TELEPHONE NUMBER _____

G P _____

ADDRESS _____

TEL. NO. _____

ENT CONSULTANT _____

DESCRIPTION OF PROBLEM (Relevant medical, educational, social history and the results of any recent assessments) Permission given to contact the child/young person's consultant/hospital _____

_____

_____

_____

*Signature of Parent/Carer _____

Referred by _____ Date _____

Address _____

_____

*Please note the referral will not be accepted without the signature of parent/carer

Return to **North Tyneside Sensory Service at Beacon Hill, Rising Sun Cottages, Wallsend, Tyne and Wear, NE28 9JW**