Queensland Government

Caboolture Hospital

COMMUNITY HEARING SCREENING PROGRAM

REFERRAL FORM

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

1. Child's Details (please complete with black pen)

Child's Family Name:	Child's Given Names:
Preferred Name:	
Child's Date of Birth: / /	Birth Sex: ☐ Male ☐ Female ☐ Indeterminate
Child's Address:	
Suburb:	Postcode:
Was the child born in Qld? ☐ Yes ☐ No	If 'YES', full name of birth mother at time of birth:

2. Parent, Legal Guardian or Approved Foster Carer Details (person completing the form)

Parent/Guardian Full Name:	Relationship to Child:
Address (if different to child's address):	
Suburb:	Postcode:
Mobile:	Home phone:
Language spoken: ☐ English ☐ Other (specify):	Interpreter required? ☐ No ☐ Yes (specify):

3. Eligibility for Screening Questions (ALL of the following questions MUST be answered)

Does the child have a Medicare Card? ☐ **Yes** ☐ No
(If 'NO', the child is **not eligible** for the hearing screening program)

Is the child aged between 9 months and 16 years of age? ☐ **Yes** ☐ No
(If 'NO', the child is **not eligible** for the hearing screening program)

Apart from hearing screening at birth has the child had their hearing tested or screened within the last 12 months? ☐ Yes ☐ **No**
(If 'YES', the child is **not eligible** for the hearing screening program)

For children under 3.5 years of age:
Did the child pass their newborn hearing screening at birth? ☐ **Yes** ☐ No ☐ Not Screened ☐ Don't know
(If any answer other than 'YES', they are **not eligible** for the hearing screening program)

If the child does not meet ALL eligibiility critieria, please contact Caboolture Hosptial Audiology on (07) 5433 8625 to discuss alternative referral options for hearing testing.

4. Pre-Screening Questions (please answer ALL of the following questions):

Are there concerns about the child's hearing? ☐ Yes (provide details): ☐ No

Are there concerns about the child's speech or language development? ☐ Yes (provide details): ☐ No

Does the child have any learning or behavioural difficulties (diagnosed or suspected)? ☐ Yes (provide details): ☐ No

Does the child require a hearing screen prior to commencing a block of therapy? ☐ Yes (Provide details): ☐ No

The hearing screen involves touching & looking into the child's ears, & having a soft probe placed in their ear for testing. They may also need to wear headphones. Do you think the child will be able to tolerate this? ☐ Yes ☐ No
If 'NO', provide details:

5. Referring Agent Details:

Name:	Position:
Organisation Name:	
Organisation Address:	
Contact Phone Number:	Date:

Email the completed referral form to:

CABH-CHSadmin@health.qld.gov.au

V1.00 - 08/2025
00030:02242