



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 eligibility criteria, please contact Caboolture Hospital 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:

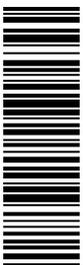
Email the completed referral form to:

**CABH-CHSadmin@health.qld.gov.au**

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All clinical form creation and amendments must be conducted through Health Information Services

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