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NHS HEARING AID REFERRAL FORM

Please fax to 01303 246571 or email hearbase.folkestone@nhs.net or
use Choose and Book. Any Questions? Phone 01303 256995 and speak to the Admin Team.

Please assess this patient for an NHS Hearing Aid/s:

1. PATIENT DETAILS

Patient Full Name: ______________________________

Gender ____________ Date of Birth: ____________ NHS No: ____________

Address: ______________________________

____

______________________________ Postcode ____________

Home Phone: ____________________ Mobile ____________________

Further info/clinical details

2. REFERRING PRACTICE DETAILS

Referring Doctor: ______________________________

Surgery Address: ______________________________

Tel No: ______________________________

Fax No: ______________________________

Email: ______________________________

Referrer's Signature: ____________________ Date of Referral: ____________