

VICTORIAN COCHLEAR IMPLANT PROGRAM REFERRAL

Client Details

Date: _____

Name		Date of birth	
Address			
Email		Phone	
Preferred contact method		Preferred location for appointment	
Preferred Language		Preferred appointment type	

Referring Clinician Details

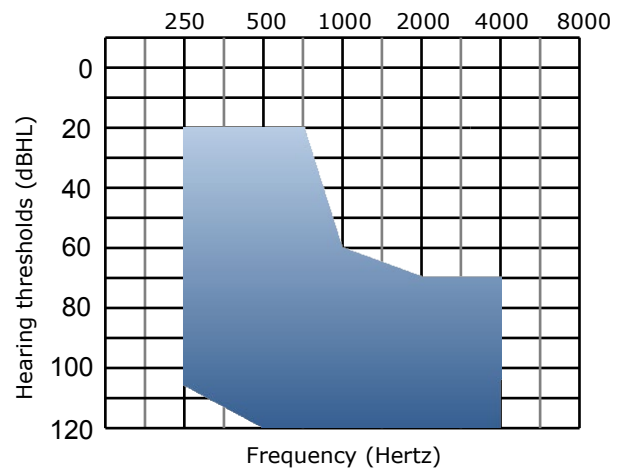
Report Included Audiogram included

Name		Organisation	
Address			
Email		Phone	

The following information may assist you when considering if an implantable hearing device is an option for improving hearing and communication:

A cochlear implant is likely to improve speech perception and clarity if a person who uses hearing aids reports:

- Reduction in clarity when listening to speech
- A reliance on lipreading or visual cues
- Difficulty communicating on the phone
- Withdrawing from social gatherings
- Hearing levels which fall into the range indicated on the audiogram to the right



Please send referrals to:

Victorian Cochlear Implant Program
Royal Victorian Eye and Ear Hospital
e-mail: VCIP@eyeandear.org.au
Fax: (03) 9929 8625
Phone: (03) 9929 8624

If you can include the following information with your referral, it would be very helpful:

- Recent (and continuous) audiogram(s)
- Degree and duration of hearing loss
- History of hearing aid use, current fitting and anything affecting hearing aid use
- Speech perception results
- Any other relevant information (e.g. medical concerns, need for interpreter, transport issues)

Please forward this form to VCIP@eyeandear.org.au at the earliest opportunity.

Please note we do not reject referrals that don't contain all of the above information and will accept a referral containing a minimum of patient name, date of birth & contact details.

Below proforma can be provided to the client to take to their GP.

Date:

Dear Doctor,

Patient name:

Address:


Date of Birth:

Recent audiological testing suggested that the above patient would benefit from further investigations to determine if a cochlear implant would be an option to improve his/her hearing.

The above patient has an outpatient appointment with us in the following **MBS BILLING CLINIC** at the Royal Victorian Eye and Ear Hospital. Could you please fill out the below referral and fax back to **9929 8625**.

Dear Royal Victorian Eye & Ear Hospital,

I wish to refer the above patient to the following clinic;

Selected Clinic (please tick)	Name of the MBS Clinic	Specialist Consultants available	
	Cochlear Implant Clinic (CICM)	Dr Robert Briggs	Dr Stephen O'Leary
		Dr Simon Ellull	Dr Markus Dahm
		Dr Elizabeth Rose	Dr Michael Tykocinski
		Dr Claire Iseli	Dr Fiona Hill
		Dr Richard Kennedy	Dr Benjamin Wei
		Dr Jean-Marc Gerard	Dr Guillermo Hurtado
		Dr Randal Leung	

Please Tick: This referral is valid for: 12 months Indefinite

Symptoms:

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Comments:

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Yours sincerely,

GP's Name/Stamp:

GP Provider No.:

Signature:

Date:



The Royal Victorian Eye and Ear hospital extends a warm welcome to Aboriginal and Torres Strait Islander patients, families and carers. We are committed to Closing the Health Gap. When attending the hospital, please let our staff know if you, or your child(ren), are of Aboriginal and/or Torres Strait Islander origin so that the appropriate services are made available to you.

