LCC D/deaf and Hard of Hearing Referral

Please answer the following questions to the best of your ability.

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| Name, address, phone, DOB and other contact details |
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| Has the person consented to a referral to LCC? |
| Yes / No |
| What is the preferred method of contact? |
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| How do they communicate? |
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| What was the outcome of audiology input? |
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| Do they have a smoke alarm? If so what type? (*battery, hardwired, etc*) |
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| Would they hear a smoke alarm at night when asleep? (*With no aids in?*) |
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| Are they able to use a telephone/mobile? |
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| Are they able to make contact with emergency services? |
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| Are they able to hear the doorbell? Do they miss visitors? |
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| Are they able to hear the TV? Is this loud enough to affect family/neighbours? |
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| Can they get out alone? |
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| Are they involved socially in the community? |
|  |
| Do they care for any children? If so what ages? |
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| Are there any other issues? |
|  |

Please e-mail this form to: [ACSCustomer.Services@lancashire.gov.uk](mailto:ACSCustomer.Services@lancashire.gov.uk)

Please use the subject "Hearing Impairment Referral"