

**Equipment Assessment**

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| TITLE: MR MRS MS MISS | | NAME | |
| ADDRESS | |  | |
| POST CODE:  DATE OF BIRTH: | | PHONE NO.  MOBILE:  EMAIL: | |
| DATE OF REFFERAL: | | REFERRED BY: | |
| REASON FOR REFFERAL: | |  | |
| Male/female | Ethnic Origin (code) | Type of residence | Category of deafness |
| OTHER CONTACT DETAILS: | |  | |
| NAME | | PHONE NO. | |
| ADDRESS | | RELATIONSHIP: | |
| APPOINTMENT DETAILS: | |  | |
| DATE: | | TIME: | |
| OFFICER | | HOME /CENTRE | |
| Risk Assessment:  Do you have a Pacemaker Y / N Epilepsy Y / N Assessment Fee Paid | | | |
| Equipment Already Held: | | | |
| EQUIPMENT ISSUED: | | | |
| GENERAL NOTES | | | |
| SIGNED OFFICER: DATE: DATABASE INPUT | | | |

 