

**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 |

 