



Guidance for Audiologists: Onward Referral of Adults with Hearing Difficulty Directly Referred to Audiology Services

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Introduction

This document is intended to guide Audiologists in service planning and in making referrals for a medical or other professional opinion.

Along with “Guidelines for Primary Care: Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016)¹”, this document replaces the earlier guidelines (BAA 2009², TTSA 1989^{3,4}) and has been approved by the Board of the British Academy of Audiology.

This document comprises a set of criteria which define the circumstances in which an Audiologist in the UK should refer an adult with hearing difficulties for a medical or other professional opinion. If any of these are found, then the patient should be referred to an Ear, Nose and Throat (ENT) department, to their GP or to an Audiologist with an extended scope of practice. The criteria have been written for all adults (age 18+), but local specifications regarding age range for direct referral should be adhered to.

This document is intended to be used in conjunction with “Guidelines for Primary Care: Direct Referral of Adults with Hearing Difficulty to Audiology Services (2016)¹”. Audiology services are expected to make reasonable efforts to make local GPs aware of this guidance and support their understanding of its application.

A simple checklist has been included as an appendix, to summarise the criteria detailed in this document.

Background

In the past, direct referral guidelines were written to provide a simple pathway to hearing aid provision for older adults (age 60+) with routine hearing loss. The age range for direct referrals now varies between services. Some Audiology services are taking direct referrals from age 16², but most take referrals from age 18 or age 50.

The criteria in this document are well accepted both in the UK and internationally^{5,6,7}. Where no published evidence is available, the criteria have been based on clinical consensus and agreed by the appropriate professional organisations. We recommend further research to provide a robust evidence base to support future guidance.

Regional Variation

The criteria listed in this document are considered to be best practice. However, the ways that Audiologists receive referrals and the services available for onward referral vary according to individual working circumstances and region.

Local arrangements may be in place for the direct referral of other conditions to Audiology, such as tinnitus, balance problems and auditory processing difficulties. Practitioners are encouraged to make use of specialist pathways which may be more appropriate, or can be used as an alternative to ENT referral^{8*}. These referral routes are outside the scope of this document, but Audiology services are encouraged to have additional protocols to allow for regional differences in referral pathways.

Local guidelines for referral into some pathways may include specific criteria in addition to those included in this document.

Scope of this Document

Audiology services are encouraged to have policies in place regarding the referral of existing hearing aid users into the Audiology service. It is best practice to work with other local providers to ensure a consistent approach when designing these policies.

Existing hearing aid users may be referred to ENT on the basis of the criteria in this document. However, detailed guidance on pre-existing conditions, previous investigations and the deterioration of hearing are beyond the scope of this document.

Audiology services are encouraged to have policies in place regarding the monitoring of adults with medical conditions which predispose them to rapid deterioration in hearing.

Prerequisites for the Assessment of Adults with hearing loss

Direct referral assessments must be conducted by a suitably qualified Healthcare Science Practitioner. For further guidance, see the current BAA Scope of Practice Document^{8*}.

This will usually be:

- A qualified Audiologist, registered with the Registration Council for Clinical Physiologists (RCCP) or Academy of Healthcare Science (AHCS).
- A Clinical Scientist (Audiology), registered with the Health and Care Professions Council (HCPC).
- A Hearing Aid Dispenser, registered with the HCPC.

This document uses the term Audiologist to refer to all of these roles.

Notes on the onward referral of adults by an Audiologist

If any of the following criteria become evident on assessment in Audiology, a medical opinion should be sought. Depending on local protocol, this referral will usually be to an Ear, Nose and Throat (ENT) department, Audiovestibular Medicine or to the GP. Where available, this may also be to an Audiology practitioner with an extended scope of practice. The reason(s) for onward referral should be explained to the patient and the referral made only after obtaining their informed consent. Pre-existing and investigated (medical) conditions should be taken into account, if relevant.

All findings and advice given must be recorded and the patient's GP informed of the outcome. This includes any onward referrals which have been made, or to inform them that a referral was recommended but consent declined.

In some services it is not possible for the Audiologist to refer directly to ENT. In this instance, a copy of the findings and the reason(s) onward referral is indicated should be issued to the patient and to their GP, with the patient's consent. The GP should then refer to ENT, including the information provided by the Audiologist.

Some Audiologists may have an extended scope of practice and provide pathways which substitute for medical referral. They must always operate within their defined professional role, according to their regional and/or professional protocols. Examples include:

- Audiologists removing ear wax.
- Undertaking vestibular function and tinnitus assessments followed by delivery and review of appropriate rehabilitation programmes.
- Assessment and consideration of audiological suitability for implantable hearing devices.
- Requesting MRI scanning in the case of an asymmetrical sensorineural hearing loss.

Referral for a medical opinion should not normally delay impression taking or hearing aid provision. The Audiologist must make a professional decision, based on ear examination, whether it is safe to proceed with impression taking⁹ and/or hearing aid fitting.

It is acknowledged that it is not always clear which adults require onward referral. Audiologists are expected to make a professional judgement, including seeking the opinion of colleagues who are more experienced, or who have specialist expertise, when appropriate.

Criteria for onward referral by the Audiologist

History:

Sudden loss or sudden deterioration of hearing (sudden = within 72 hours), unilateral or bilateral, should be sent to A&E or Urgent Care ENT clinic within 24 hours. Due to the variety of causes of sudden hearing loss, the treatment timescale should be decided locally by the medical team. Prompt treatment may increase the likelihood of recovery^{10,11,12}.

Altered sensation or numbness in the face¹³ or observed facial droop. Urgent medical advice should be sought if these symptoms have not previously been investigated.

Persistent pain affecting either ear, which is intrusive and which has not resolved as a result of prescribed treatment. (As a general guideline, this includes pain in or around the ear, lasting a week or more in recent months).

History of discharge (other than wax) from either ear within the last 90 days, which has not resolved or responded to prescribed treatment, or which is recurrent.

Rapid loss or rapid deterioration of hearing (rapid = 90 days or less)¹⁴.

Fluctuating hearing loss, other than associated with colds.

Hyperacusis. (An intolerance to everyday sounds that causes significant distress and impairment in social, occupational recreational and other day to day activities).

Tinnitus, which is persistent and which:

- is unilateral
- is pulsatile
- has significantly changed in nature
- is leading to sleep disturbance or is associated with symptoms of anxiety or depression

(For further guidance on the referral of adults with tinnitus, please see related evidence^{15,16,17}).

Vertigo which has not fully resolved, or which is recurrent. (Vertigo is classically described as a hallucination of movement, but here includes any dizziness or imbalance that may indicate otological, neurological or medical conditions. Examples include headaches with associated dizziness, spinning, swaying or floating sensations and veering to the side when walking. For further guidance on vertigo, see www.vestibular.org¹⁸).

Normal peripheral hearing, but with altered auditory perceptions or abnormal difficulty hearing in noisy backgrounds. This may include having problems with sound localisation, the perception of pitch and loudness or difficulty following complex auditory directions^{19,20}.

Ear examination:

Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression. If wax is obscuring the eardrum or there is a current infection, local wax care or treatment procedures should be followed.

Abnormal appearance of the outer ear and/or the eardrum (Examples include²¹: inflammation of the external auditory canal, perforated eardrum, active discharge, eardrum retraction, abnormal bony or skin growths, swelling of the outer ear or blood in the ear canal).

Tympanometry (performed if there is any indication of middle ear effusion):

Unilateral flat tympanogram, regardless of the associated level of hearing loss^{22,23}.

Audiometry:

Conductive hearing loss, defined as 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz^{24,25}. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist²⁶.

Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds (masked as appropriate) of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist)^{27,28,29}. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months, defined as a deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.

Other findings:

Any other unusual presenting features at the discretion of the Audiologist or according to the requirements of the service to which the adult is being referred. Audiologists are expected to use their professional judgement and relevant guidance to make appropriate onward referrals for adults requiring Audiology services beyond their own scope of practice (for example, due to hearing loss complexity or co-existing conditions³⁰). Such referrals may be made in addition to a referral for a medical opinion.

Adults with sensorineural hearing loss which does not appear to be age related should, where appropriate, be offered a referral for aetiological investigation³¹.

Conclusion

This document has listed the criteria for Audiologists to consider when assessing adults with hearing difficulties who have been directly referred (or self-referred) into the Audiology service. This should ensure that adults receive further assessment and care, with the correct professionals, when it is appropriate.

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(A copy can be found within "Hearing and Balance Disorders; Achieving excellence in diagnosis and management"⁴)

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*(Please note that this is under review at the time of writing and the latest version should be consulted.)

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Appendix – Onward referral of patient by an Audiologist (summary)

History	
Sudden loss or sudden deterioration of hearing (Sudden = within 72 hours)	Send to A&E or Urgent Care ENT clinic.
Altered sensation or numbness in the face, or facial droop	Yes / No
Persistent pain affecting either ear	Yes / No
History of discharge (other than wax) from either ear within the last 90 days	Yes / No
Rapid loss or rapid deterioration of hearing (rapid = 90 days or less)	Yes / No
Fluctuating hearing loss, other than associated with colds	Yes / No
Hyperacusis	Yes / No
Tinnitus which: is unilateral is pulsatile has significantly changed in nature is leading to sleep disturbance or is associated with symptoms of anxiety or depression.	Yes / No
Vertigo which has not fully resolved or which is recurrent. a hallucination of movement any dizziness or imbalance that may indicate otological, neurological or medical conditions examples include headaches with associated dizziness, spinning, swaying or floating sensations and veering to the side when walking	Yes / No
Normal peripheral hearing, but with altered auditory perceptions	Yes / No
Ear Examination	
Complete or partial obstruction of the external auditory canal preventing full examination of the eardrum and/or proper taking of an aural impression.	Yes / No
Abnormal appearance of the outer ear and/or the eardrum	Yes / No

Tympanometry (if performed)	
Unilateral flat tympanogram, regardless of the associated level of hearing loss.	Yes / No
Audiometry	
Conductive hearing loss 20 dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist	Yes / No
Unilateral or asymmetrical sensorineural hearing loss A difference between the left and right bone conduction thresholds of 20 dB or greater at two or more adjacent frequencies: 500, 1000, 2000, 4000 or 8000Hz. (Other frequencies may be included at the discretion of the Audiologist).	Yes / No
Evidence of deterioration of hearing by comparison with an audiogram taken in the last 24 months A deterioration of 15 dB or more in bone conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. In the absence of recordable bone conduction thresholds, air conduction thresholds should be considered instead.	Yes / No
Other	
Any other unusual presenting features at the discretion of the Audiologist. Please give details below:	Yes / No