Onward Referral Guidance for Adult Audiology Patients

Joint guidance from BAA & BSHAA

Published TBC

Due for Review TBC

Contents

Contents 2

Acknowledgements 3

Introduction 3

Scope 4

Regional Variation 4

Referral Pathway 5

When a referral may not be required 6

Criteria For Referral 8

Emergency & Urgent Referrals 8

Sudden or rapid onset of hearing loss 8

Hearing loss with specific additional symptoms or signs 8

Specialist Referrals 9

Adults with suspected or diagnosed dementia, mild cognitive impairment, or a learning disability 10

Post Audiology Assessment Referrals 11

Cochlear Implant Referrals 11

Appendix – Referral Checklist 12

Adults with suspected or diagnosed dementia, mild cognitive impairment, or a learning disability 14

Acknowledgements

Thanks…

Introduction

This document is intended to guide GPs, Audiologists, Health and Care Professions Council Registered Hearing Aid Dispensers, Hearing Care Assistants and other audiology professionals, in service planning and when to refer patients for a medical or other professional opinion.

Referral means sharing relevant information with and/or making arrangements for a patient to be seen by another professional for the investigation, treatment or management of a symptom or condition that is outside your scope of practice or service to manage.

Onward referral may be made by anyone with the appropriate training, knowledge and skills to do so.

This document comprises a set of criteria which define the circumstances in which an Audiologist in the UK should refer an adult service user for a medical or other professional opinion. If any of these criteria are met, 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.

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

This guidance has been written in line with the following NICE guidance:
NICE NG98 https://www.nice.org.uk/guidance/ng98/chapter/Recommendations
NICE TA566 https://www.nice.org.uk/guidance/ta566

Scope

This document is aimed at services, professionals and clinicians who have the responsibility for providing care to adult audiology patients aged 18 and over.

Both new patient's (new referral) and existing service users may be referred onwards for a specialist opinion 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.

Regional Variation

The criteria listed in this document are considered to be best practice. However, the ways that services 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, wax removal, 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. 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.

Referral Pathway

GPs should:

For adults who present for the first time with hearing difficulties, or in whom hearing difficulties are suspected:

- exclude impacted wax and acute infections such as otitis externa, **then**
- refer the patient for an audiological assessment, **and**
- refer to referral criteria to determine if an emergency, urgent or specialist referral is also required

Audiology professionals shall:

If during an audiological assessment, any of the listed conditions in criteria for referral below become evident, 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 back 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. The referral recipient should be informed in writing and without undue delay, and with all the relevant and necessary information and/or test results e.g. audiograms etc. Pre-existing and investigated (medical) conditions should be taken into account, if relevant.

All findings and advice given must be recorded and, with patient consent, made available to any referring professional. Where any onward referrals have have been made to specialist opinion or investigions or a referral was recommended but declined, the GP must be informed regardless of the referral route.

In some services it is not possible for the Audiologist to refer directly to the required service. In this instance, a copy of the findings and the reason(s) for onward referral should be sent or given to the patient and to their GP, with the patient's consent. The GP should then refer on for a specialist opinion and or investigations, such as ENT or falls clinic, 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 testing and/or 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.

Where any of the signs or symptoms listed in the criteria for referral below have not been dealt with previously or not satisfactorily treated/managed, and are outside scope of practice then referral for a medical opinion should be made. Clinicians are encouraged to make their own professional judgement whether a patient's condition is outside their scope of practice.

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 taking 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.

When a referral may not be required

Clinicians, in consultation with the patient, might make a professional judgement that an onward referral is not the preferred course of action. This may arise if:

- The patient has already been referred by another professional for investigation of the condition.
- The condition has been fully investigated by an appropriate qualified professional, any possible treatment has been provided and the condition remains unchanged, since the treatment/management. Audiology clinicians should ensure that there are clinical notes available to them as the clinical evidence for this, where possible.
- The condition lies within the audiology clinician's scope of practice, because they have training and experience in dealing with the condition e.g. Hearing Aid Dispensers/Audiologists appropriately trained to remove ear wax or deal with bilateral tinnitus with symmetrical hearing loss.
- The patient has made an informed and competent decision and declined a referral. In this case, the audiology clinician must make appropriate records of the basis on which this decision has been reached. They must ensure that informed consent has been obtained from the patient or their carer or other competent advisor on the basis of sufficient information including associated risks, and the records confirm all the necessary considerations about patient's best interests.

In all the above situations the audiology clinician should try and obtain a written consent acknowledging the risks of both, not referring and also proceeding with management options such as fitting of hearing devices (where applicable) and inform the patient's GP about their decision.

Criteria For Referral

Emergency & Urgent Referrals

Sudden or rapid onset of hearing loss

Refer adults with sudden onset or rapid worsening of hearing loss in one or both ears, which is not explained by external or middle ear causes, as follows:

- If the hearing loss developed suddenly (over a period of 3 days or less) within the past 30 days, refer immediately (to be seen within 24 hours) to an ear, nose and throat service or an emergency department.
- If the hearing loss developed suddenly more than 30 days ago, refer urgently (to be seen within 2 weeks) to an ear, nose and throat or audiovestibular medicine service.
- If the hearing loss worsened rapidly (over a period of 4 to 90 days), refer urgently (to be seen within 2 weeks) to an ear, nose and throat or audiovestibular medicine service.

Hearing loss with specific additional symptoms or signs

- Refer immediately (to be seen within 24 hours) adults with acquired unilateral hearing loss and altered sensation or facial droop on the same side to an ear, nose and throat service or, if stroke is suspected, follow a local stroke referral pathway.
- Refer immediately (to be seen within 24 hours) adults with hearing loss who are immunocompromised and have otalgia (ear ache) with otorrhoea (discharge from the ear) that has not responded to treatment within 72 hours to an ear, nose and throat service.
- Consider making an urgent referral (to be seen within 2 weeks) to an ear, nose and throat service for adults of Chinese or south-east Asian family origin who have hearing loss and a middle ear effusion not associated with an upper respiratory tract infection.

Specialist Referrals

Consider referring adults with hearing loss that is not explained by acute external or middle ear causes to an ear, nose and throat, audiovestibular medicine or specialist audiology service for diagnostic investigation, using a local pathway, if they present with any of the following:

- Unilateral or asymmetric hearing loss as a primary concern.
- Hearing loss that fluctuates and is not associated with an upper respiratory tract infection.
- Hyperacusis (intolerance to everyday sounds that causes significant distress and affects a person's day-to-day activities).
- Persistent tinnitus that is either unilateral, pulsatile, has significantly changed in nature or is causing distress.
- Vertigo that has not fully resolved or is recurrent.
- Hearing loss that is not age related.

Consider referring adults with hearing loss to an ear, nose and throat service if, after initial treatment of any earwax or acute infection, they have any of:

- Partial or complete obstruction of the external auditory canal that prevents full examination of the eardrum or taking an aural impression.
- Pain affecting either ear (including in and around the ear) that has lasted for 1 week or more and has not responded to first-line treatment.
- A history of discharge (other than wax) from either ear that has not resolved, has not responded to prescribed treatment, or recurs.
- Abnormal appearance of the outer ear or the eardrum, such as:
    - inflammation
    - polyp formation
    - perforated eardrum
    - abnormal bony or skin growths
    - swelling of the outer ear
    - blood in the ear canal
- A middle ear effusion in the absence of, or that persists after, an acute upper respiratory tract infection.

Offer MRI of the internal auditory meati to adults with hearing loss and localising symptoms or signs (such as facial nerve weakness or unilateral tinnitus) that might indicate a vestibular schwannoma or CPA (cerebellopontine angle) lesion, irrespective of pure tone thresholds.

Adults with suspected or diagnosed dementia, mild cognitive impairment, or a learning disability

- Consider referring adults with diagnosed or suspected dementia or mild cognitive impairment to an audiology service for a hearing assessment because hearing loss may be a comorbid condition.
- Consider referring adults with diagnosed dementia or mild cognitive impairment to an audiology service for a hearing assessment every 2 years if they have not previously been diagnosed with hearing loss.
- Consider referring people with a diagnosed learning disability to an audiology service for a hearing assessment when they transfer from child to adult services, and then every 2 years.

Post Audiology Assessment Referrals

- Consider referring for an MRI of the internal auditory meati for adults with sensorineural hearing loss and no localising signs if there is an asymmetry on pure tone audiometry of 15 dB or more at any 2 adjacent test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz.
- Referral for implantable devices such as cochlear implants, bone-anchored hearing aids, middle-ear implants or auditory brain stem implants, if these might be suitable.
- Referral for medical or surgical treatments, if these might be suitable.
- 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. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the Audiologist.

Cochlear Implant Referrals

Cochlear implantation is recommended as an option for people with severe to profound* deafness who do not receive adequate benefit** from acoustic hearing aids.

*for this guidance, severe to profound deafness is defined as hearing only sounds that are louder than 80 dB HL (pure-tone audiometric threshold equal to or greater than 80 dB HL) at 2 or more frequencies (500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz and 4,000 Hz) bilaterally without acoustic hearing aids.

**Adequate benefit from acoustic hearing aids is defined for this guidance as a phoneme score of 50% or greater on the Arthur Boothroyd word test presented at 70 dBA.

Appendix – Referral Checklist

Emergency/Immediate referral (within 24 hours)	
Sudden hearing loss which developed over a period of 3 days or less within the past 30 days	Emergency ENT
Acquired unilateral hearing loss and altered sensation or facial droop on same side	Emergency ENT or Stroke Referral
Immunocompromised adults with otalgia and otorrhoea that has not responded to treatment within 72 hours	Emergency ENT
Urgent Referral (Within 2 weeks)	
Sudden hearing loss which developed more than 30 days ago	ENT or Audiovestibular medicine
Rapid hearing loss which developed over a period of 4 to 90 days	ENT or Audiovestibular medicine
Adults of Chinese or south-east Asian family origin who have hearing loss and a middle ear effusion not associated with an upper respiratory tract infection	ENT
Specialist Referral	
Unexplained unilateral or asymmetric hearing loss	ENT, Audiovestibular medicine or specialist audiology service
Fluctuating hearing loss not associated with an upper respiratory tract infection	ENT, Audiovestibular medicine or specialist audiology service
Hyperacusis (intolerance to everyday sounds that causes significant distress and affects a person's day-to-day activities)	ENT, Audiovestibular medicine or specialist audiology service
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. A lesser conductive hearing loss in the presence of bilateral	ENT, Audiovestibular medicine or specialist audiology service

middle ear effusion may be referred at the discretion of the Audiologist	
Persistent tinnitus that is: • Unilateral • Pulsatile • Has significantly changed in nature **OR** • Is causing distress	ENT, Audiovestibular medicine or specialist audiology service
Vertigo that has not fully resolved or is recurrent	ENT, Audiovestibular medicine or specialist audiology service
Hearing loss that is not age related	ENT, Audiovestibular medicine or specialist audiology service
Partial or complete obstruction of the external auditory canal that prevents full examination of the eardrum or taking an aural impression	ENT, Audiovestibular medicine or specialist audiology service
Pain affecting either ear (including in and around the ear) that has lasted for 1 week or more and has not responded to first-line treatment	ENT, Audiovestibular medicine or specialist audiology service
History of discharge (other than wax) from either ear that has not resolved, has not responded to prescribed treatment, or recurs	ENT, Audiovestibular medicine or specialist audiology service
Abnormal appearance of the outer ear or the eardrum, such as: • inflammation • polyp formation • perforated eardrum • abnormal bony or skin growths • swelling of the outer ear • blood in the ear canal	ENT, Audiovestibular medicine or specialist audiology service
Middle ear effusion in the absence of, or that persists after, an acute upper respiratory tract infection	ENT, Audiovestibular medicine or specialist audiology service

Adults with hearing loss and localising symptoms or signs (such as facial nerve weakness) that might indicate a vestibular schwannoma or CPA (cerebellopontine angle) lesion, irrespective of pure tone thresholds	MRI/Radiology
Adults with suspected or diagnosed dementia, mild cognitive impairment, or a learning disability	
Diagnosed or suspected dementia or mild cognitive impairment	GP for referral to Audiology service
Diagnosed dementia or mild cognitive impairment every 2 years if they have not previously been diagnosed with hearing loss	GP for referral to Audiology service
Diagnosed learning disability to an audiology service for a hearing assessment when they transfer from child to adult services, and then every 2 years	GP for referral to Audiology service
Post Audiometry Assessment Referral	
Asymmetric sensorineural hearing loss of 15 dB or more at any 2 adjacent test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz. and/or unilateral tinnitus	MRI/Radiology
Referral for implantable devices such as cochlear implants, bone-anchored hearing aids, middle-ear implants or auditory brain stem implants, if these might be suitable	Cochlear Implant Centre/Service
Referral for medical or surgical treatments, if these might be suitable	ENT
Patients with severe to profound hearing loss who do not receive adequate benefit from hearing aids	Cochlear Implant Centre/Service