BRITISH ACADEMY
OF AUDIOLOGY

Onward Referral Guidance for Adult Audiology Service Users

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Contents

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The BAA would like to thank everyone that took part in the production and public consultation of this document and all authors of the previous versions.

A slight change has been made to this version to add clarity around the asymmetrical criteria, the urgent referral criteria for certain ethnic groups and a clearer definition of rapid.

Introduction

This document is intended to guide Audiologists, Hearing Aid Dispensers, Hearing Care Assistants, and other audiology professionals on who may be suitable for direct referral to audiology and when to refer service users for a medical or other specialist opinion. For the purpose of this document the term Audiologist is used throughout but is intended to apply to all professions. When reading this document and seeing service users, patient centred should always be followed using professional judgement.

Referral means sharing relevant information with and/or making arrangements for a service user 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 (defined as over 18 years of age) service user for a medical or other specialist opinion. If any of these criteria are met, then the service user should be referred to an Ear, Nose and Throat (ENT) department, to their GP, to an audiologist with an extended scope of practice or to another suitable specialist in keeping with local protocol. The criteria have been written for all adults, but local specifications regarding age range for direct referral should be adhered to.

A 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 older.

Both new service users (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 exact levels which determine a 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 for example those on ototoxic treatment.

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. General 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 variations in referral pathways.

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

Referral Pathway

Audiology professionals shall:
If during an audiological assessment, any of the listed conditions for referral below become evident, a medical/specialist opinion should be sought. Depending on local protocol, this referral will usually be direct to an Ear, Nose and Throat (ENT) department or Audiovestibular Medicine. Where available, this may also be to an audiology practitioner with an extended scope of practice.

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 service user 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.

The reason(s) for onward referral should be explained to the service user 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 clearly recorded and, with the service user's consent, made available to any referring professional. Where any onward referrals have been made to specialist opinion / investigations or a referral was recommended but declined, this again should be clearly documented and the service user's GP must be informed, regardless of the referral route.

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

- Removing ear wax.
- Undertaking vestibular function testing and/or tinnitus assessments.
- Assessment and consideration of audiological suitability for bone conduction/middle ear/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 the audiologist's scope of practice then referral for a medical/specialist opinion should be made. Audiologists are encouraged to make their own professional judgement whether a service user's condition is outside their scope of practice but should be able to clearly justify their decision making.

Referral for a medical/specialist opinion should not normally delay impression taking or provision of hearing devices. The audiologist must make a professional decision, based on case history and ear examination, whether it is safe to proceed with impression taking and/or fitting of hearing devices.

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 service user, might make a professional judgement that an onward referral is not the preferred course of action. This may arise if:

- The service user 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. Audiologists should ensure that there are clinical notes available to them as the clinical evidence for this, where possible.
- The condition lies within the audiologists scope of practice because they have training and experience in dealing with the condition e.g. Audiologists appropriately trained to remove ear wax or deal with bilateral tinnitus with symmetrical hearing loss.
- The service user has made an informed and competent decision and declined a referral. In this case, the audiologist 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 service user or their carer/significant other or other competent advisor on the basis of sufficient information, including associated risks, and the records confirm all the necessary considerations about the best interests of the service user.

In all the above situations the audiologist should try and obtain 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 service users 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 ENT 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 ENT or Audiovestibular medicine service.
- If the hearing loss worsened rapidly (within the last 4 to 90 days), refer urgently (to be seen within 2 weeks) to an ENT or Audiovestibular medicine service.

Hearing loss with specific additional symptoms or signs

- Refer immediately (to be seen within 24 hours) service users with acquired unilateral hearing loss and altered sensation or facial droop on the same side to an ENT service or, if stroke is suspected, follow a local stroke referral pathway.
- Refer immediately (to be seen within 24 hours) service users 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 ENT service.
- Refer urgently (to be seen within 2 weeks) service users of North African, Inuit, Yupik, Chinese or south-east Asian family origin who have hearing loss and a middle ear effusion not associated with an upper respiratory tract infection to an ENT service[1].

Specialist Referrals

Service users with hearing loss that is not explained by acute external or middle ear causes should be referred to an ENT, 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 or pulsatile or has significantly changed in nature within the last 6 months or is causing distress.
- Vertigo or dizziness that has not fully resolved or is recurrent.
- Hearing loss that is not age related.

Audiologists should refer service users to an ENT Audiovestibular medicine or specialist audiology service, using a local pathway if, after initial treatment of any earwax or acute infection, they have any of:

- A remaining partial or complete obstruction of the external auditory meatus that prevents full examination of the tympanic membrane 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.
- Any abnormal appearance of the outer ear or the tympanic membrane, such as:
    - inflammation
    - polyp formation
    - perforated tympanic membrane
    - 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.

Audiologists should either refer to an ENT, Audiovestibular medicine or specialist audiology service, using a local pathway service users with localising symptoms or signs (such as facial nerve weakness or unilateral tinnitus) that might indicate a vestibular schwannoma or CPA (cerebellopontine angle) lesion, for MRI of the internal auditory meati irrespective of pure tone thresholds where they do not offer direct referral for this themselves.

Post Audiology Assessment Referrals

Post audiological assessment, the following service users should be referred to an ENT, Audiovestibular medicine or specialist audiology service, using a local pathway:

- Unilateral or Asymmetrical sensorineural hearing loss and no localising signs if there is an asymmetry on pure tone audiometry of 15dB or more at any 2 adjacent air or bone conduction test frequencies, using test frequencies of 500, 1000, 2000, 4000 and 8000 Hz where direct referral for MRI is not available.
- Hearing losses which may be suitable for implantable devices such as cochlear implants, bone-anchored hearing aids, middle-ear implants, or auditory brain stem implants, if these might be suitable.
- Conductive hearing loss, defined as 20dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. – testing of bone conduction thresholds at 3000 and 4000Hz would only be necessary if one of other frequency shows a conductive loss of 20dB or greater air bone gap. A lesser conductive hearing loss in the presence of bilateral middle ear effusion may be referred at the discretion of the audiologist.

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 within the last 4 to 90 days	ENT or Audiovestibular medicine
Service users of North African, Inuit, Yupik, 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 service user's day-to-day activities)	ENT, Audiovestibular medicine or specialist audiology service
Conductive hearing loss, defined as 20dB or greater average air-bone gap over three of the following frequencies: 500, 1000, 2000, 3000 or 4000 Hz. – testing of bone conduction thresholds at 3000 and 4000Hz would only be necessary if one of other frequency shows a conductive loss of 20dB or greater air bone gap. A lesser conductive hearing loss in	ENT, Audiovestibular medicine or specialist audiology service

the presence of bilateral middle ear effusion may be referred at the discretion of the audiologist.	
Persistent tinnitus that is: • Unilateral • Pulsatile • Has significantly changed in nature in the last 6 months **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 meatus 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
Post Audiometry Assessment Referral	
Asymmetrical hearing loss of 15dB or more at any 2 adjacent air or bone conduction test frequencies, using test frequencies of 0.5, 1, 2, 4 and 8 kHz.	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
Patients with severe to profound hearing loss who do not receive adequate benefit from hearing aids	Cochlear Implant Centre/Service

References

1. Ruan HL, Qin HD, Shugart YY, Bei JX, Luo FT, Zeng YX, Jia WH. Developing genetic epidemiological models to predict risk for nasopharyngeal carcinoma in high-risk population of China. PLoS One. 2013;8(2):e56128