

## British Academy of Audiology Guidelines for Referral to Audiology of Adults with Hearing Difficulty (2009)

This document is intended both as a basis for service planning and to guide the practice of those who make direct referral of adults to Audiology services, primarily GPs. A simple checklist for use by Audiology departments to ensure that the guidelines have been followed is included as an appendix. This document replaces the earlier guide (TISA, 1989) and has been approved by the Board of the British Academy of Audiology.

The guidelines comprise a set of contra-indications for adult (16+ years) *direct* referral to Audiology for hearing assessment and rehabilitative treatment either from Primary Care or via other intra-hospital Consultant pathways.

The contra-indications may be evident at the time of referral, in which case the patient should normally be referred to ENT in the first instance. Contra-indications may additionally become evident on assessment<sup>1</sup> in Audiology, in which case medical opinion should be sought regarding potential referral to ENT. This may require the patient to be seen by a medical practitioner in clinic, or may be based on discussion of relevant findings between the medical practitioner and audiologist. 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. Findings, whether positive or negative, and any advice given regarding these conditions must be recorded and the patient's GP informed. Pre-existing and investigated (medical) conditions should be taken into account if relevant.

### Contra-indications

#### *History:*

- Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment);
- History of discharge other than wax from either ear within the last 90 days
- Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)
- Rapid loss or rapid deterioration of hearing (rapid=90 days or less)
- Fluctuating hearing loss, other than associated with colds
- Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time
- Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression
- Abnormal auditory perceptions (dysacusis)

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<sup>1</sup> Direct referral assessments must be conducted by suitably qualified staff, normally supervised by a qualified Audiologist registered with RCCP, or a Clinical Scientist (Audiology) registered with HPC.

- Vertigo<sup>2</sup>
- Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.

*Ear examination:*

- Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression.
- Abnormal appearance of the outer ear and/or the eardrum (e.g., inflammation of the external auditory canal, perforated eardrum, active discharge).

*Audiometry:*

- Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.
- Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.
- 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 air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.

*Other findings:*

- Any other unusual presenting features at the discretion of the audiologist.

**Notes**

Where audiologists are not qualified (according to local guidelines) to undertake wax removal, or where any findings indicate possible need for further specialist assessment (e.g. otological, medical, neurological, neuro-otological), a medical opinion (normally from ENT or Audiovestibular Medicine) is required. Example findings include: middle ear disease or indications for acoustic neuroma.

Where agreement has been reached with local medical staff, audiologists may undertake extended roles that substitute for parts of the medical opinion referred to above. They must always operate within defined local 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 bone anchored hearing aids and cochlear

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<sup>2</sup> Vertigo is classically described hallucination of movement, but here includes dizziness, swaying or floating sensations (frequently associated with unsteadiness) that may indicate otological, neurological or medical conditions.

implants; referring directly for MRI scanning in the case of an asymmetrical sensorineural hearing loss.

**References:**

Criteria for direct referral: Guidelines of the Liaison Group of Technicians, Therapists and Scientists in Audiology (TTSA), BAAS Newsletter 1989

HAC Code of Practice, Examinations and Registration – September 2004 Edition

British Academy of Audiology: 14<sup>th</sup> September 2009

**Appendix 1 – BAA Guidelines for Referral to Audiology of Adults with Hearing Difficulty  
Direct Referral Checklist (2009)**

<b>History</b>	
Persistent pain affecting either ear (defined as earache lasting more than 7 days in the past 90 days before appointment)	Yes / No
History of discharge other than wax from either ear within the last 90 days	Yes / No
Sudden loss or sudden deterioration of hearing (sudden=within 1 week, in which case send to A&E or Urgent Care ENT clinic)	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
Unilateral or asymmetrical, or pulsatile or distressing tinnitus lasting more than 5 minutes at a time	Yes / No
Troublesome, tinnitus which may lead to sleep disturbance or be associated with symptoms of anxiety or depression	Yes / No
Abnormal auditory perceptions (dysacusis)	Yes / No
Vertigo including dizziness, swaying or floating sensations	Yes / No
Normal peripheral hearing but with abnormal difficulty hearing in noisy backgrounds; possibly having problems with sound localization, or difficulty following complex auditory directions.	Yes / No
<b>Ear examination</b>	
Complete or partial obstruction of the external auditory canal preventing proper examination of the eardrum and/or proper taking of an aural impression.	Yes / No
Abnormal appearance of the outer ear and/or the eardrum (e.g., inflammation of the external auditory canal, perforated eardrum; active discharge).	Yes / No
<b>Audiometry</b>	
Conductive hearing loss, defined as 25 dB or greater air-bone gap present at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.	Yes / No
Unilateral or asymmetrical sensorineural hearing loss, defined as a difference between the left and right bone conduction thresholds of 20 dB or greater at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.	Yes / No
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 air conduction threshold readings at two or more of the following frequencies: 500, 1000, 2000 or 4000 Hz.	Yes / No
<b>Other</b>	
Any other unusual presenting features at the discretion of the audiologist.	Yes / No
... please give details	

\*\*\* If any of the answers above is Yes, seek medical opinion \*\*\*