Sawston Microsuction Service

Microsuction Referral Proforma

Patient Details		
Name:		
NHS Number:		
Date of Birth:		
Address:	....	
Clinician Details		
Name of Referring Clinician:		**Date:**
Practice:		
Practice Telephone Number:		

Reason for referral			
Wax removal	☐	**Removal of foreign body**	☐
Mastoid cavity	☐	**Narrow canal**	☐
Altered anatomy	☐	**Remove debris**	☐

		Y	**N**
Risk of bleeding (warfarin, aspirin haemophilia**)**		☐	☐
Able to give valid consent		☐	☐
Previous difficulties with microsuction	**N/A** ☐	☐	☐
History of severe dizziness		☐	☐
Able to keep head still		☐	☐
Hyperacusis		☐	☐

Right ear	☐	**Left Ear**	☐	**Both**	☐

Please enter referral letter text here (optional). Please expand or shrink box as required.