**Please complete the following proforma to allow us to ensure we see the patient in the appropriate facial palsy appointment. Thank you.**

|  |  |
| --- | --- |
| **Diagnosis:** | Click here to enter text. |
| **Date of onset:**  | Click here to enter a date. |
| **Side of facial palsy:**  | Left [ ]  Right [ ]  Bilateral [ ]   |
|  **Speed of Onset**  | Sudden/Acute [ ]  Gradual over 3+ weeks [ ]  Recurrent [ ]   |

**Please now answer the following questions regarding the patients’ facial palsy:**

|  |
| --- |
| **SYMPTOMS (Please choose the appropriate answer)** |
| 1 | No return of **any** facial function after 6 months | Yes [ ]  No [ ]  |
| 2 | Incomplete facial palsy\* | Yes [ ]  No [ ]  |
| 3 | Polycranial neuropathy\*\* | Yes [ ]  No [ ]  |
| 4 | Prolonged, severe ear or facial pain | Yes [ ]  No [ ]  |
| 5 | Ear discharge | Yes [ ]  No [ ]  |
| 6 | Mass in the ear, parotid region or the neck | Yes [ ]  No [ ]  |
| 7 | Previous history of cancer, significant unexplained weight loss, other red flags | Yes [ ]  No [ ]  |
| 8 | History of bullseye rash (indicative of Lyme Disease) | Yes [ ]  No [ ]  |
| 9 | Altered behaviour patterns or severe psychological issues | Yes [ ]  No [ ]  |

**Please add any additional information here:**

|  |
| --- |
| Click here to enter text. |
| *Please also attach the patients’ medical history and a list of medication with your referral. Thank you.* |
| **Name of referrer:** |  |
| **Designation:** |  |
| **Signature:** |  |

*\** Incomplete facial palsy (with sparing of certain parts of the face) that has not resolved within 2 months

\*\*Polycranial neuropathy e.g. double vision, reduced eye movement, unexplained hearing or balance loss, corneal numbness, swallowing issues.