Date: [Insert Date]
To: Audiology Department / Specialist Name
Facility: [Insert Facility Name]
Address: [Insert Address]

RE: Patient Referral for Audiological Assessment

Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
Contact Number: [Insert Phone Number]
Address: [Insert Patient Address]

Dear Audiologist,

I am referring this patient for a comprehensive audiological evaluation to assist in ENT clinical management.

Reason for Referral / Clinical History:

- [e.g., Progressive bilateral hearing loss]
- [e.g., Tinnitus: Left/Right/Bilateral]
- [e.g., History of chronic otitis media]
- [e.g., Dizziness or Vertigo symptoms]

Otoscopic Findings:

[Insert findings, e.g., Clear canals, intact tympanic membranes, or effusion noted]

Requested Tests:

- Pure Tone Audiometry (Air and Bone conduction with masking)
- Speech Audiometry (Discrimination scores)
- Immittance Testing (Tympanometry and Acoustic Reflexes)
- [Optional: OAE / BERA / Vestibular Testing]

Please forward the results and your recommendations to my office upon completion of the assessment.

Thank you for your assistance in the care of this patient.

Sincerely,

[Doctor Signature]
[Doctor Name]
[Department/Clinic Name]
[Contact Information]