Date: [Insert Date]

To: Audiology Department / [Audiologist Name]
From: [Referring Physician Name]
Facility: [Clinic/Hospital Name]

RE: PEDIATRIC AUDIOLOGY ASSESSMENT REFERRAL

Patient Name: [Child's Full Name]
Date of Birth: [DOB]
Parent/Guardian: [Name]
Phone Number: [Phone Number]

Reason for Referral:

- [ ] Failed Newborn Hearing Screen
- [ ] Parental concern regarding hearing/speech delay
- [ ] History of recurrent Otitis Media
- [ ] Monitoring due to ototoxic medication
- [ ] Chronic Eustachian Tube Dysfunction
- [ ] Other: [Specify]

Relevant Clinical History:
[Insert brief history, including relevant ENT findings, surgical history like PE tubes, or developmental milestones.]

Requested Evaluation:

- [ ] Comprehensive Audiological Evaluation (VRA/CPA)
- [ ] Tympanometry and Acoustic Reflex Testing
- [ ] Otoacoustic Emissions (OAE)
- [ ] Auditory Brainstem Response (ABR) - Sedated/Unsedated

Please provide a full report following the assessment for clinical review.

Sincerely,

[Signature]
[Physician Name]
[NPI Number]
[Contact Information]