Date: [Insert Date]

To: Department of Otolaryngology / Audiology
Facility: [Insert Hospital/Clinic Name]
Address: [Insert Address]

URGENT REFERRAL: Audiology Assessment

Patient Details:
Name: [Patient Full Name]
DOB: [Date of Birth]
Address: [Patient Address]
Phone: [Patient Phone Number]

Reason for Urgent Referral:
[e.g., Sudden Sensorineural Hearing Loss / Acute Ototoxicity / Traumatic Hearing Loss]

Clinical History:
[Provide brief description of onset, duration, and severity of symptoms. Note if the loss is unilateral or bilateral.]

Associated Symptoms:
[ ] Tinnitus
[ ] Vertigo/Dizziness
[ ] Otalgia (Ear Pain)
[ ] Otorrhea (Discharge)
[ ] Neurological Deficits

Examination Findings:
[Insert Weber/Rinne results or Otoscopy findings here]

Current Medications:
[List any relevant medications, specifically steroids if already initiated]

Requested Action:
Requesting urgent diagnostic audiometry and specialist ENT consultation to determine management and prevent permanent auditory damage.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

[Your Professional Title]
[Your Contact Information]