

Date: [Insert Date]

To: [Recipient Name/Department]

Clinic: [Otolaryngology / Audiology Department Name]

Address: [Clinic Address]

RE: Patient Referral for Tinnitus Evaluation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Contact Number: [Phone Number]

Dear Specialist,

I am referring this patient for a comprehensive otolaryngological and audiological evaluation regarding persistent tinnitus.

Clinical History:

- **Duration:** [e.g., 6 months]
- **Lateralization:** [Left / Right / Bilateral]
- **Type:** [e.g., Constant / Intermittent / Pulsatile]
- **Associated Symptoms:** [e.g., Hearing loss, Vertigo, Otolgia, Aural fullness]
- **Impact:** [e.g., Sleep disturbance, Anxiety, Difficulty concentrating]

Relevant Medical Background:

[Insert brief medical history, current medications, or history of noise exposure]

Requested Services:

- Diagnostic Audiogram (Air and Bone conduction)
- Speech Discrimination Testing
- Tympanometry and Acoustic Reflexes
- Otolaryngology consultation to rule out underlying pathology

Thank you for seeing this patient in consultation. Please forward the results of your evaluation and recommended management plan to my office.

Sincerely,

[Your Name/Signature]

[Practice Name]

[Contact Information]