

**Date:** [Date]

**To:** Audiology Department

**From:** [Surgeon Name/ENT Clinic]

**Subject:** Post-Operative Audiology Assessment Referral

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Patient ID/MRN:** [ID Number]

**Contact Number:** [Phone Number]

**Surgery Performed:** [Type of Surgery, e.g., Myringoplasty, Stapedectomy, Mastoidectomy]

**Date of Surgery:** [Surgery Date]

**Operated Ear:** [Left / Right / Bilateral]

**Reason for Referral:**

Please perform a formal post-operative audiological evaluation to assess hearing status and surgical outcome.

**Requested Assessments:**

- Pure Tone Audiometry (Air and Bone Conduction)
- Speech Audiometry
- Tympanometry and Acoustic Reflexes
- [Other: e.g., Bone Anchored Hearing Aid (BAHA) Evaluation]

**Clinical Notes / Precautions:**

[e.g., Avoid pressure on ear canal, status of tympanic membrane graft, or persistent tinnitus.]

**Follow-up:**

Please forward the results to [Physician Name] at [Fax Number/Email] prior to the patient's next appointment on [Date].

Sincerely,

[Signature]

[Printed Name]

[Title/Position]

[Facility Name]