

**Date:** [Date]

**To:** [Cochlear Implant Center Name]

**Attn:** Cochlear Implant Team / Otolaryngology & Audiology

**Address:** [Clinic Address]

**Fax/Email:** [Contact Details]

**RE: Referral for Cochlear Implant Candidacy Evaluation**

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

**Date of Birth:** [DOB]

**Insurance:** [Insurance Provider & ID Number]

Dear Cochlear Implant Team,

I am referring the above-named patient for a comprehensive cochlear implant candidacy evaluation. The patient presents with bilateral sensorineural hearing loss and reports significantly limited benefit from appropriately fitted hearing aids.

**Clinical Summary:**

- **Hearing History:** [Brief history, e.g., Progressive loss, sudden loss, or congenital]
- **Current Amplification:** [Type of hearing aids used and duration of use]
- **Recent Audiometric Results:** [Insert brief summary of SRT/WRS if known]
- **Communication Difficulties:** [e.g., Difficulty on telephone, struggling in background noise, social isolation]

The patient is motivated to explore surgical intervention and advanced hearing technology to improve their communicative function and quality of life.

Attached please find the patient's most recent audiogram and relevant clinical notes. Please contact our office if any further documentation is required for the evaluation or insurance authorization.

Thank you for your expertise in evaluating this patient.

Sincerely,

[Referring Provider Name, Degree]

[Practice Name]

[Phone Number]

[Signature/NPI]