Date: [Date]

To: [Audiologist Name/Clinic Name]
Address: [Clinic Address]
Fax/Phone: [Contact Information]

RE: Patient Referral for Audiological Assessment
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Gender: [Gender]
Phone: [Patient Phone Number]

Dear Audiology Department,

I am referring this patient for a formal audiological evaluation due to concerns regarding their hearing health and communication function.

Reason for Referral:

- [ ] Gradual hearing loss (bilateral/unilateral)
- [ ] Tinnitus evaluation
- [ ] Cognitive decline/dementia screening related to hearing loss
- [ ] Balance/Dizziness concerns
- [ ] Difficulty hearing in background noise
- [ ] Evaluation for hearing amplification (Hearing Aids)

Relevant Medical History:

[Insert brief history, e.g., History of noise exposure, cerumen impaction, ototoxic medications, or use of assistive devices.]

Requested Services:

- Comprehensive Audiometry (Air and Bone Conduction)
- Speech Reception Thresholds and Word Recognition Scoring
- Tympanometry and Acoustic Reflex Testing
- Hearing Aid Consultation (if indicated)

Special Considerations for Geriatric Care:

[Note any mobility issues, cognitive impairment, or communication preferences here.]

Please provide a copy of the test results and your recommendations to my office upon completion of the assessment.

Sincerely,

Signature: _____
Physician Name: [Provider Name]
Clinic Name: [Clinic/Department Name]
NPI Number: [NPI Number]
Contact Details: [Phone/Email]