

Date: [Insert Date]

To: [Otolaryngology/Audiology Department Name]

Recipient Name: [Specialist Name, if known]

Facility Address: [Insert Address]

RE: Routine Screening Referral

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Contact Number: [Phone Number]

Dear Doctor/Audiologist,

I am referring this patient for a routine screening evaluation. This referral is based on [Routine age-based protocol / Workplace health requirement / General health maintenance].

Clinical Indications:

- Requested Service: [Comprehensive Audiogram / Tympanometry / ENT Clearance]
- Current Symptoms: [None/Asymptomatic or list minor concerns]
- Relevant History: [e.g., Family history of hearing loss, noise exposure, or none]

Current Medications:

[List medications or "None"]

Please provide a copy of the diagnostic results and any clinical recommendations following the assessment.

Thank you for your assistance in this patient's care.

Sincerely,

[Your Name/Signature]

[Provider Title]

[Clinic Name]

[Contact Information]