Date: [Insert Date]

To: Department of Otolaryngology / ENT Triage

From: [Referring Physician Name]
Clinic: [Clinic Name/Address]
Contact: [Phone Number]

URGENT REFERRAL: TINNITUS ASSESSMENT

Patient Name: [Patient Full Name]
DOB: [Date of Birth]
Health Number: [ID Number]
Phone: [Patient Phone Number]

Reason for Urgent Referral:

- [ ] Sudden Onset Sensorineural Hearing Loss (SNHL) - within [X] hours/days
- [ ] Pulsatile Tinnitus (Synchronous with heartbeat)
- [ ] Unilateral Tinnitus (Asymmetric)
- [ ] Associated Neurological Deficits / Cranial Nerve Involvement
- [ ] Severe Psychological Distress / Risk of Self-Harm

Clinical Presentation:
[Briefly describe duration, laterality, and sound quality of tinnitus]

Associated Symptoms:
[e.g., Vertigo, Aural Fullness, Otalgia, Otorrhea, Facial Weakness]

Physical Exam Findings:
Otoscopy: [Normal/Abnormal Findings]
Tuning Fork Tests (Weber/Rinne): [Results if performed]

Relevant History/Malignancy Risk:
[Insert relevant medical history, medications, or noise exposure]

Requested Action:
Urgent specialist evaluation and diagnostic imaging (MRI/CT) or Audiometry as deemed necessary.

Sincerely,

[Signature]

[Physician Name and Billing Number]