

Date: [Date]

From:

[Referring Physician Name]

[Referring Clinic Name]

[Address]

[Phone Number]

To:

[Receiving Specialist Name/Clinic]

[Department of Otolaryngology/Audiology]

[Address]

RE: Transfer of Care / Referral for Tinnitus Management

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID: [ID Number]

Dear [Recipient Name],

I am formally transferring the care of the above-named patient to your clinic for specialized assessment and management of [Subjective/Objective] Tinnitus.

Clinical Summary:

The patient has been experiencing tinnitus in the [Left/Right/Both] ear(s) for [Duration]. The onset was [Sudden/Gradual]. The sound is described as [Ringing/Buzzing/Hissing/Pulsatile].

Associated Symptoms:

[List symptoms such as Hearing Loss, Vertigo, Otalgia, or Aural Fullness].

Relevant History & Diagnostics:

[Summarize relevant medical history, noise exposure, or medications]. Attached are the results for:

- [Audiogram Date]
- [Imaging Results e.g., MRI/CT if applicable]
- [Tinnitus Handicap Inventory Score if available]

Current Medications:

[List Medications]

Reason for Transfer:

[Specify reason: e.g., Tinnitus Retraining Therapy (TRT) evaluation, Sound Therapy, or Rule out underlying pathology].

Please assume primary management of this patient's tinnitus care moving forward. I would appreciate receiving your consultation notes and any recommended treatment plans.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Credentials]