Date: [Insert Date]

To: [Recipient Physician Name]
Address: [Recipient Address]
Fax/Phone: [Recipient Contact Info]

RE: [Patient Full Name]
Date of Birth: [Patient DOB]
Diagnosis: Chronic Tinnitus (ICD-10: H93.1)

Dear Dr. [Recipient Last Name],

I am referring the above-named patient for a formal evaluation and development of a comprehensive treatment plan for chronic tinnitus.

Clinical History:
The patient reports persistent auditory sensations in the [Left/Right/Both] ear(s) described as [Ringing/Buzzing/Hissing]. The symptoms have persisted for [Duration] and are reported as [Mild/Moderate/Severe] in intensity. The patient's Tinnitus Handicap Inventory (THI) score is currently [Score, if known].

Associated Symptoms:
[ ] Hearing Loss
[ ] Vertigo/Dizziness
[ ] Otalgia
[ ] Sleep Disturbance
[ ] Anxiety/Depression related to symptoms

Previous Interventions:
[List previous treatments, medications, or audiology tests performed].

Requested Consultation Goals:
1. Comprehensive Audiological Evaluation and Tinnitus Matching.
2. Rule out underlying vascular or neurological etiologies.
3. Assessment for sound therapy, hearing aids, or maskers.
4. Recommendation for Tinnitus Retraining Therapy (TRT) or Cognitive Behavioral Therapy (CBT) if applicable.

Please provide a summary of your findings and any specific recommendations for ongoing management. Thank you for your assistance in this patient's care.

Sincerely,

[Your Name/Signature]
[Your Title]

[Your Practice Name]
[Contact Information]