Date: [Date]

To: [Specialist Name/Pediatric Otolaryngology Department]
Facility: [Hospital/Clinic Name]
Address: [Street Address, City, State, Zip]

RE: Referral for Pediatric Tinnitus Consultation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Parent/Guardian: [Name]
Phone Number: [Phone Number]

Dear Dr. [Specialist Last Name],

I am referring this patient for a formal otolaryngology evaluation regarding persistent tinnitus. The patient describes the sound as [ringing / buzzing / clicking / pulsing] in the [left / right / both] ear(s).

Clinical Presentation:

- **Duration:** [How long symptoms have lasted]
- **Associated Symptoms:** [Hearing loss / Vertigo / Otalgia / Aural fullness]
- **Pulsatile Nature:** [Yes / No]
- **Impact:** [Effect on sleep, school, or anxiety levels]

Medical History:

- History of ear infections or surgery: [Details]
- History of noise exposure: [Details]
- Current Medications: [List medications]
- Relevant Family History: [Details]

Recent Findings:

[Include results of any previous physical exams, audiograms, or imaging studies performed].

Please evaluate this patient for further diagnostic testing and management recommendations. Thank you for your consultation.

Sincerely,

[Referring Physician Name]
[Practice Name]
[Phone Number]
[Fax Number]