Audiology Service Referral Request

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Referring Physician: [Referring Physician's Name]

Date: [Current Date]

To: [Audiology Service Provider's Name]

[Audiology Service Provider's Address]

[City, State, Zip Code]

Dear [Audiology Service Provider's Name],

I am writing to refer my patient, [Patient's Full Name], for an audiology evaluation. The patient has been experiencing [briefly describe symptoms, e.g., "hearing loss," "tinnitus," etc.] since [duration of symptoms].

Clinical details:

- History of [relevant medical history]
- Current medications: [list medications]
- Previous treatments: [list previous treatments or interventions]

Please conduct a comprehensive audiological assessment and provide recommendations for further management. The patient's insurance information is as follows:

Insurance Provider: [Insurance Provider]

Policy Number: [Policy Number]

Thank you for your assistance in this matter. Please do not hesitate to contact me at [Your Phone Number] or [Your Email Address] for any further information.

Sincerely,

[Your Name]

[Your Title]

[Your Practice Name]

[Your Practice Address]

[City, State, Zip Code]