

Date: [Insert Date]

To: [Consultant Name/Maternal-Fetal Medicine Department]

Facility: [Hospital/Clinic Name]

Address: [Address, City, State, Zip Code]

RE: Referral for High-Risk Obstetric Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

EDD/Gestational Age: [Estimated Due Date / Current Weeks]

Dear Dr. [Consultant Last Name],

I am referring the above-named patient to your care for specialized high-risk obstetric management due to the following indication(s):

- [Reason 1: e.g., Pre-eclampsia, Gestational Diabetes]
- [Reason 2: e.g., Multiple Gestation, Advanced Maternal Age]
- [Reason 3: e.g., Previous Pre-term Labor, Pre-existing Cardiac Condition]

Clinical Summary:

[Provide a brief history of current pregnancy, relevant past medical/surgical history, and current medications.]

Recent Test Results:

[Attach or list relevant lab work, ultrasound findings, or blood pressure readings.]

I would appreciate your evaluation and recommendations for the ongoing management of this pregnancy. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Credentials]

[Practice Name]