Date: [Insert Date]

To: Gastroenterology Department / Endoscopy Unit
Facility Name: [Insert Hospital/Clinic Name]
Address: [Insert Address]

RE: Referral for Upper Gastrointestinal Endoscopy (OGD)

Patient Details:
Name: [Patient Full Name]
DOB: [Date of Birth]
Gender: [Gender]
Contact Number: [Phone Number]
Address: [Patient Address]

Dear Dr. [Consultant Name or "Endoscopist"],

I am writing to formally request an Upper Gastrointestinal Endoscopy for the above-named patient.

Clinical Indications/Reason for Referral:
[e.g., Persistent dyspepsia, Dysphagia, Unexplained weight loss, Suspected peptic ulcer, Reflux refractory to PPI therapy, Hematemesis, Melena]

Clinical History:
[Provide brief summary of symptoms, duration, and severity]

Current Medications:
[List medications, specifically noting anticoagulants, antiplatelets, or NSAIDs]

Relevant Medical History:
[List comorbidities, allergies, and previous abdominal surgeries]

Urgency:
[ ] Routine
[ ] Urgent / Fast-Track (2-week rule)

Thank you for your assistance in the management of this patient. Please contact my office if further information is required.

Sincerely,

[Doctor's Signature]
[Doctor's Name]
[Practice Name/ID]
[Contact Information]