Date: [Date]

To: [Consultant Name]
Department: Pediatric Gastroenterology / Endoscopy Unit
Facility: [Hospital/Clinic Name]

RE: Referral for Pediatric Endoscopy

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

Dear Doctor,

I am writing to formally request a pediatric endoscopic evaluation for the patient named above.

Requested Procedure:
[ ] Esophagogastroduodenoscopy (EGD / Upper GI Endoscopy)
[ ] Colonoscopy
[ ] Flexible Sigmoidoscopy
[ ] Biopsy as indicated

Clinical Indication & History:
[Briefly describe symptoms, e.g., chronic abdominal pain, persistent vomiting, rectal bleeding, suspected IBD, or failure to thrive].

Relevant Diagnostic Results:
[List relevant lab work, imaging, or previous stool studies].

Current Medications:
[List medications and dosages].

Allergies:
[List allergies or state 'NKDA'].

Please evaluate this patient for the appropriate procedure and advise the family regarding necessary bowel preparation or fasting protocols. Please send a copy of the procedure report and pathology results to my office.

Sincerely,

[Your Signature]
[Your Printed Name]

[Your Practice/Clinic Name]
[Your Contact Information]