

**Date:** [Date]

**To:** [Recipient Name/Specialist]

**Clinic:** [Clinic Name]

**Address:** [Clinic Address]

**RE: Referral for Surgical Excision of Ingrown Toenail**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

Dear [Specialist Name],

I am referring this patient for urgent evaluation and surgical management of an ingrown toenail involving the [Left/Right] [Digit Location].

**Medical History:**

The patient has a diagnosis of Diabetes Mellitus (Type [1/2]). Their most recent HbA1c was [Value] on [Date].

**Clinical Presentation:**

The patient presents with [Pain/Swelling/Erythema/Purulent Drainage] at the affected site. Symptoms have persisted for [Duration].

**Risk Factors:**

- Peripheral Neuropathy: [Yes/No]
- Peripheral Vascular Disease: [Yes/No]
- History of Foot Ulcers: [Yes/No]

**Current Management:**

[List any antibiotics or conservative treatments tried]

Due to the patient's diabetic status and the increased risk of infection or ulceration, I request your expertise for a partial or full nail avulsion/matricectomy.

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Practice Name]