Date: [Date]

To: [Referring Physician Name]
Address: [Clinic/Hospital Address]

RE: [Patient Full Name]
DOB: [Date of Birth]
ID: [Patient ID Number]

Dear Dr. [Referring Physician Last Name],

Thank you for requesting a cardiology evaluation for [Patient Name] regarding suspected arrhythmia.

Chief Complaint:
The patient presents with [symptoms: e.g., palpitations, dizziness, syncope, or shortness of breath]. These episodes began [timeframe] and occur [frequency].

History of Present Illness:
[Brief description of triggers, duration of episodes, and any associated chest pain or lightheadedness].

Clinical Findings:
Blood Pressure: [BP] mmHg
Heart Rate: [HR] bpm
Physical Exam: [Brief findings, e.g., regular rhythm, no murmurs, clear lungs].

Diagnostic Data:
EKG: [Findings, e.g., Sinus rhythm with PACs/PVCs, Atrial Fibrillation, etc.]
Holter/Event Monitor: [Results or pending status]
Echocardiogram: [EF% and structural findings if available]

Assessment/Impression:
1. [Primary Arrhythmia Diagnosis or Differential]
2. [Secondary Diagnosis/Contributing factors like Hypertension]

Plan:
- **Medication:** [New prescriptions or changes to current dose]
- **Testing:** [Ordered tests, e.g., Stress test, Electrophysiology study]
- **Follow-up:** [Timeline for next visit]

I will update you as further test results become available. Please contact my office if you have any questions.

Sincerely,

[Doctor Name], MD/DO
[Cardiology Department Name]
[Contact Information]