Date: [Insert Date]

To: [Consultant Name/Geriatric Cardiology Department]
Facility: [Facility Name]
Fax/Address: [Insert Contact Info]

RE: Patient Consultation Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Phone Number: [Patient Phone]

Dear Dr. [Consultant Last Name],

I am referring this [Age]-year-old patient to your geriatric cardiology service for evaluation and management recommendations regarding: [Primary Cardiac Diagnosis/Reason for Referral].

Clinical Concerns:
[Briefly describe symptoms, e.g., syncope, heart failure exacerbation, or valvular disease in the context of frailty.]

Geriatric Considerations:
[List specific concerns: e.g., Polypharmacy, Cognitive impairment, Falls/Gait instability, or Goals of care discussion.]

Relevant Medical History:
[List major comorbidities]

Current Medications:
[List or attach current medication list]

Recent Test Results:
[List recent Echo, EKG, or Stress Test results if available]

We are specifically seeking your expertise regarding [e.g., medication optimization, procedural risk assessment, or conservative management strategies].

Thank you for participating in the care of this patient. Please contact my office at [Your Phone Number] if you require further information.

Sincerely,

[Your Name/Signature]
[Your Title]
[Clinic/Organization Name]