Date: [Date]

To: [Referring Provider Name]
Address: [Provider Address]
Fax/Email: [Provider Contact Info]

RE: [Patient Name]
DOB: [Patient Date of Birth]

Dear [Referring Provider Name],

Thank you for referring [Patient Name] for a psychiatric diagnostic assessment. I evaluated the patient on [Date of Evaluation].

Chief Complaint:
[Briefly describe the patient's primary reason for seeking treatment]

History of Present Illness:
[Summary of symptoms, duration, and severity]

Mental Status Examination:
[Summary of findings regarding appearance, behavior, mood, affect, thought process, and safety]

Diagnostic Impression (ICD-10):
1. [Primary Diagnosis Code and Name]
2. [Secondary Diagnosis Code and Name]

Treatment Plan:
[Summary of medication prescribed, therapy recommendations, and follow-up schedule]

I look forward to collaborating with you on this patient's care. If you have any questions, please contact my office at [Your Phone Number].

Sincerely,

[Your Signature/Name]
[Your Credentials]
[Practice Name]