[Date]

[Referring Provider Name]
[Clinic Name]
[Address]
[City, State, Zip]

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

Dear Dr. [Referring Provider Last Name],

Thank you for referring [Patient Name] for a pediatric psychiatric diagnostic assessment. I evaluated the patient on [Date of Evaluation] accompanied by [Parent/Guardian Name].

Reason for Referral:
[Briefly describe the primary concerns and symptoms].

Clinical Findings:
The assessment included a review of developmental history, current symptoms, and a mental status examination. [Insert brief summary of key clinical observations].

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

Treatment Plan and Recommendations:

- **Medication:** [Specific medication started/adjusted or "No medications recommended at this time"].
- **Therapy:** [Recommendation for CBT, Family Therapy, Play Therapy, etc.].
- **School Interventions:** [Recommendation for 504 Plan, IEP, or classroom accommodations].
- **Follow-up:** The patient is scheduled to return to my office on [Date/Time].

It is a pleasure to participate in the care of your patient. Please contact my office at [Phone Number] if you have any questions or require further coordination of care.

Sincerely,

[Your Signature]
[Your Printed Name, Credentials]
[Practice Name]