[Date]

[Referring Physician Name]
[Clinic/Institution Name]
[Address]
[City, State, Zip Code]

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

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] for a geriatric psychiatric diagnostic assessment regarding [Reason for Referral, e.g., memory loss, behavioral disturbances, or late-life depression].

History of Present Illness

[Insert brief summary of current symptoms, onset, duration, and impact on daily functioning/ADLs].

Psychiatric and Medical History

Past Psychiatric History: [Insert history/prior treatments]
Past Medical History: [Insert relevant conditions, e.g., hypertension, diabetes, TIA]
Current Medications: [List medications and dosages]

Mental Status Examination

Appearance/Behavior: [Observations]
Mood/Affect: [Patient's report and clinical observation]
Thought Process/Content: [Linearity, delusions, hallucinations]
Cognitive Screening: [Score and name of tool used, e.g., MMSE or MoCA score]

Diagnostic Impression

Based on today's assessment, the clinical findings are consistent with:

- [Diagnosis 1/ICD-10 Code]
- [Diagnosis 2/ICD-10 Code]

Recommendations and Plan

1. [Medication changes or new prescriptions]
2. [Recommended laboratory work or neuroimaging]

3. [Non-pharmacological interventions/Safety recommendations]
4. [Follow-up schedule]

It is a pleasure to participate in the care of your patient. Please contact my office if you have any questions.

Sincerely,

[Your Name, MD/DO/NP]
[Title]
[Contact Information]