**Date:** [Date]

**To:** [Referring Physician Name]
**Department:** [Referring Department/Service]
**Facility:** [Hospital Name]

**RE: Patient Name:** [Patient Full Name]
**Date of Birth:** [DOB]
**Medical Record Number:** [MRN]
**Date of Consultation:** [Consult Date]

Dear [Referring Physician Name],

Thank you for requesting a psychiatric consultation for [Patient Name]. I performed a formal diagnostic assessment on [Date] at the request of [Requesting Provider/Team] to evaluate [Reason for Referral, e.g., altered mental status, mood instability, capacity evaluation].

## Subjective History

[Brief summary of history of present illness, psychiatric history, and substance use history.]

## Mental Status Examination

- **Appearance:** [Description]
- **Behavior:** [Description]
- **Speech:** [Rate, volume, tone]
- **Mood:** [Patient's reported mood]
- **Affect:** [Observed affect, range, congruency]
- **Thought Process:** [Linear, disorganized, etc.]
- **Thought Content:** [Delusions, hallucinations, suicidal/homicidal ideation]
- **Cognition:** [Orientation, memory, attention]
- **Insight/Judgment:** [Description]

## Diagnostic Impression

Based on the clinical interview and review of available records, the patient meets criteria for:

1. [Primary Diagnosis/ICD-10 Code]
2. [Secondary Diagnosis]
3. [Medical Comorbidities impacting mental health]

## Assessment and Recommendations

[Summary of clinical findings and rationale for treatment plan.]

**Proposed Plan:**

- [Medication recommendations and dosages]
- [Behavioral interventions or safety precautions]
- [Recommended laboratory work or imaging]
- [Follow-up frequency and discharge planning recommendations]

Thank you for the opportunity to assist in this patient's care. Please contact the psychiatry consult service at [Phone/Pager Number] for any further questions.

Sincerely,

[Your Signature]
[Your Printed Name and Title]
[Your Contact Information]