

Date: [Insert Date]

To: [Recipient Name/Department]

Facility: [Medical Center Name]

Address: [Street Address, City, State, Zip]

RE: Referral for Genetic Evaluation and Testing

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/MRN: [ID Number]

Dear Genetic Consultation Team,

I am referring this patient for a formal genetic evaluation and diagnostic testing due to a clinical presentation of developmental delay. The patient is currently demonstrating significant delays in the following areas:

- [e.g., Gross/Fine Motor Skills]
- [e.g., Speech and Language Development]
- [e.g., Cognitive/Social Functioning]

Clinical Background:

[Briefly describe medical history, physical findings, or relevant family history here].

Requested Services:

We request a comprehensive dysmorphology examination and genetic counseling. Based on current clinical guidelines, we recommend consideration for the following tests if deemed appropriate by your team:

- Chromosomal Microarray Analysis (CMA)
- Fragile X Syndrome Testing
- Whole Exome Sequencing (WES) / Multigene Panel

The goal of this referral is to identify an underlying genetic etiology to guide future medical management, determine recurrence risks for the family, and coordinate necessary interventions.

Please find the attached clinical notes and previous laboratory results. Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Your Name/Signature]

[Your Title/Credentials]

[Clinic Name]