Date: [Date]

To: [Gastroenterologist Name]
Facility: [Clinic/Hospital Name]
Address: [Recipient Address]

RE: Referral for Diagnostic Upper Endoscopy (EGD)
Patient Name: [Patient Name]
Date of Birth: [DOB]
Insurance: [Insurance Provider & ID]

Dear Dr. [Recipient Last Name],

I am referring this patient to your care for a diagnostic upper gastrointestinal endoscopy.

Clinical Indications/Symptoms:
[e.g., Persistent epigastric pain, dysphagia, hematemesis, refractory GERD, or unexplained weight loss]

Pertinent Medical History:
[Brief history of GI issues, previous surgeries, or relevant comorbidities]

Current Medications:
[List medications, especially anticoagulants or NSAIDs]

Specific Requests:
[e.g., Biopsy for H. pylori, evaluation of Barrett's esophagus, or dilation if indicated]

Please evaluate the patient and proceed with the procedure as clinically indicated. Following the consultation and procedure, please forward a copy of the endoscopy report and pathology results to my office.

Thank you for your assistance in the management of this patient.

Sincerely,

[Physician Signature]
[Referring Physician Name]
[Practice Name]
[Phone Number]
[Fax Number]