

**Date:** [Date]

**To:** Gastroenterology Department / Endoscopy Suite

**From:** [Referring Physician Name]

**Facility:** [Clinic/Hospital Name]

**Contact Number:** [Phone Number]

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## **URGENT REFERRAL: GASTROINTESTINAL BLEEDING**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Medical Record Number:** [MRN]

### **Clinical Presentation:**

- Onset of Symptoms: [Time/Date]
- Type: [Hematemesis / Melena / Hematochezia]
- Current Vitals: BP: [BP], HR: [HR], Temp: [Temp], O2 Sat: [O2]

### **Laboratory Findings:**

- Hemoglobin/Hematocrit: [Value]
- Platelets: [Value]
- INR/PTT: [Value]
- BUN/Creatinine: [Value]

### **Medical History & Medications:**

[Relevant history: e.g., PUD, Cirrhosis, Anticoagulant use, NSAID use]

### **Current Management:**

[IV Fluids, Proton Pump Inhibitors, Transfusions administered]

### **Request:**

Urgent evaluation for diagnostic and therapeutic endoscopy (EGD/Colonoscopy) due to suspected active gastrointestinal hemorrhage.

Sincerely,

[Signature]  
[Printed Name]  
[License Number]