Date: [Date]

To: [Gastroenterologist Name/Endoscopy Department]
Facility: [Facility Name]
Address: [Facility Address]

RE: Referral for Endoscopy (Colonoscopy)

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Health Insurance: [Insurance Provider & ID Number]

Dear Doctor,

I am referring this patient to your care for a diagnostic colonoscopy following a **positive Fecal Occult Blood Test (FOBT/FIT)** completed on [Date].

Clinical Indications:

- Positive Fecal Occult Blood Test (FOBT)
- [Optional: Additional symptoms such as change in bowel habits or abdominal pain]
- [Optional: Family history of colorectal cancer]

Medical History & Medications:

[List relevant medical history and current medications, especially anticoagulants or antiplatelet agents].

Requested Action:

Please evaluate the patient for a screening/diagnostic colonoscopy and provide a consultation report following the procedure.

Thank you for your assistance in this patient's care. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name]
[Clinic Name]
[NPI Number]