

Date: [Date]

To: [Gastroenterologist Name]

Department: Gastroenterology/Endoscopy Unit

Facility: [Facility Name]

RE: Referral for Diagnostic Upper Endoscopy (EGD)

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Insurance Provider: [Insurance Name/ID]

Dear Dr. [Gastroenterologist Last Name],

I am referring this patient to your clinic for a formal consultation and diagnostic upper endoscopy (EGD) to evaluate symptoms of chronic acid reflux (GERD).

Clinical History:

The patient has been experiencing persistent symptoms of [heartburn/regurgitation/dysphagia] for [Duration]. Despite a trial of [Specific Medications, e.g., Omeprazole 20mg] for [Number] weeks, the patient continues to experience breakthrough symptoms.

Reason for Referral:

The primary goals of this evaluation are to:

- Assess for erosive esophagitis or strictures.
- Screen for Barrett's Esophagus.
- Rule out Hiatal Hernia or malignancy.
- Evaluate for H. pylori or Eosinophilic Esophagitis via biopsy if indicated.

Current Medications:

[List medications here]

Allergies:

[List allergies here]

Please find the attached recent lab results and clinical notes. We would appreciate your specialist evaluation and a copy of the procedure report following the intervention.

Sincerely,

[Referring Physician Signature]

[Referring Physician Name]

[Clinic Name]

[Phone Number]