Date: [Insert Date]

To: [Consultant/Specialist Name]
Department: [Department Name, e.g., Maternal-Fetal Medicine]
Facility: [Hospital/Clinic Name]

RE: Referral for Fetal Growth Restriction (FGR) Consultation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Gestational Age: [Weeks/Days]

Dear Dr. [Last Name],

I am referring this patient for a formal consultation and co-management regarding suspected Fetal Growth Restriction (FGR). This diagnosis was prompted by [mention clinical finding, e.g., fundal height lag or routine ultrasound].

Clinical Findings:

- **Estimated Fetal Weight (EFW):** [Weight] ([Percentile] percentile)
- **Abdominal Circumference (AC):** [Measurement] ([Percentile] percentile)
- **Amniotic Fluid Index (AFI) or Deepest Vertical Pocket:** [Measurement]
- **Umbilical Artery Doppler:** [Normal / Elevated PI / Absent or Reversed End Diastolic Velocity]

Relevant History:

[Insert brief history: e.g., Hypertension, smoking status, previous FGR, or relevant lab results.]

Consultation Request:

I request your expert evaluation, including a detailed anatomy scan (if not recently performed), Doppler studies, and recommendations for the ongoing frequency of surveillance and the optimal timing of delivery.

The patient is aware of the findings and is prepared for this consultation. Please find the attached ultrasound reports and prenatal records for your review.

Thank you for your assistance in this patient's care.

Sincerely,

[Your Name/Signature]
[Your Title/Credential]
[Contact Information]