

Date: [Insert Date]

To: [Consultant Name/Rheumatology Department]

Facility: [Hospital/Clinic Name]

Address: [Facility Address]

RE: Referral for Autoimmune Diagnostic Consultation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Health Insurance/ID: [ID Number]

Dear Dr. [Consultant Last Name],

I am writing to formally refer this patient for a diagnostic evaluation regarding a suspected systemic autoimmune or inflammatory rheumatic disease.

Clinical Presentation:

The patient has been experiencing the following symptoms for [Duration]:

- [e.g., Symmetrical joint pain and swelling]
- [e.g., Prolonged morning stiffness exceeding 60 minutes]
- [e.g., Unexplained fatigue and low-grade fever]
- [e.g., Photosensitive malar rash]

Pertinent Examination Findings:

[Describe physical findings, such as synovitis, decreased range of motion, or skin lesions].

Initial Laboratory and Imaging Results:

- ANA: [Result/Titer/Pattern]
- ESR/CRP: [Values]
- RF / Anti-CCP: [Results]
- Imaging: [Brief summary of X-ray or Ultrasound findings]

Current Medications:

[List current medications and any trial of NSAIDs or Steroids].

Reason for Referral:

To confirm a diagnosis and initiate an appropriate management plan, including potential Disease-Modifying Antirheumatic Drugs (DMARDs).

Thank you for your expertise in reviewing this case. Please contact my office if any further information is required.

Sincerely,

[Doctor Name]

[Practice Name]

[Phone Number]
[Email Address]