Date: [Insert Date]

To: [Recipient Name/Specialist Name]
Facility: [Clinic/Hospital Name]
Address: [Recipient Address]

RE: Referral for Initial Concussion Consultation

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Date of Injury: [Date of Incident]

Dear [Recipient Name],

I am referring this patient to your care for a formal concussion consultation and management plan. The patient sustained a head injury resulting from [Brief Description of Mechanism, e.g., a fall, sports collision, or motor vehicle accident].

Initial Clinical Presentation:

- Loss of consciousness: [Yes/No/Unknown]
- Confusion or amnesia: [Yes/No]
- Initial GCS score: [Score, if applicable]

Current Symptoms:
[List symptoms, e.g., headache, dizziness, light sensitivity, cognitive fog, or nausea]

Interventions to Date:
[List any imaging, rest protocols, or medications prescribed]

Please provide a comprehensive assessment, including recommendations for return-to-learn or return-to-play protocols. I have attached the relevant clinical notes and any diagnostic imaging reports for your review.

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

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Credentials]
[Contact Information]