Date: [Date]

To: [Specialist Name/Clinic Name]
Address: [Specialist Address]
Fax/Phone: [Specialist Contact Information]

RE: Referral for Specialized Concussion Management

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

Dear Dr. [Specialist Last Name],

I am referring this patient to your care for evaluation and management of prolonged concussion symptoms (Post-Concussion Syndrome). It has been [Number] weeks since the initial head injury, and the patient continues to experience significant symptoms that interfere with their daily functioning.

Mechanism of Injury:
[Briefly describe how the injury occurred, e.g., motor vehicle accident, sports injury, or fall].

Current Persistent Symptoms:
[List symptoms, e.g., persistent headaches, dizziness, cognitive fog, light sensitivity, or sleep disturbances].

Treatments to Date:
[List medications, physical therapy, or modifications already attempted].

Requested Evaluation:
I would appreciate your specialist assessment regarding [Specific concern, e.g., vestibular therapy, neurocognitive testing, or headache management] and your recommendations for a multidisciplinary recovery plan.

Please find the attached initial injury report and relevant clinical notes. Thank you for your assistance with this patient's recovery.

Sincerely,

[Your Name/Signature]
[Title/Credentials]
[Clinic Name]
[Phone Number]