Date: [Insert Date]

Patient Name: [Insert Name]
Date of Birth: [Insert DOB]
Patient Address: [Insert Address]

Referring Provider: [Insert Doctor Name]
Consulting Specialist: [Insert Specialist Name]

Subject: Referral for Endometriosis and Fertility Assessment

Dear Dr. [Specialist Last Name],

I am referring this patient for a comprehensive gynecological consultation regarding suspected/confirmed endometriosis and its impact on her future fertility.

Clinical Presentation:
The patient reports the following symptoms: [List symptoms, e.g., chronic pelvic pain, dysmenorrhea, dyspareunia]. Symptoms have persisted for [Duration].

Current Findings:
[List relevant ultrasound or MRI findings, or previous laparoscopic results].

Fertility Context:
The patient is currently [trying to conceive / planning for future conception]. We request an assessment of her ovarian reserve and a discussion regarding management options that prioritize the preservation of fertility, including:

- Staging of endometriosis.
- Assessment of tubal patency and ovarian function.
- Surgical vs. medical management risks/benefits regarding fertility.
- Potential referral for egg freezing or IVF if indicated.

Medical History:
[Briefly list relevant history or medications].

Thank you for your expert evaluation and recommendations for this patient.

Sincerely,

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