Date: [Insert Date]

To: [Consultant Name/Fertility Clinic Name]
Department: Reproductive Medicine / Gynecology

RE: Referral for Fertility Assessment and Management
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Address: [Patient Address]
Partner Name (if applicable): [Partner Name/DOB]

Dear Doctor,

I am writing to formally refer this patient for a specialist fertility consultation. The patient and their partner have been trying to conceive for [Number] months/years without success.

Clinical History:

- **Menstrual Cycle:** [Regular/Irregular], [Length] days.
- **Obstetric History:** [G-P- status / Previous pregnancies or miscarriages].
- **Medical History:** [Relevant conditions, e.g., PCOS, Endometriosis, Surgery].
- **Medications:** [List medications].

Preliminary Investigation Results:

- **Hormonal Profile:** Day 3 FSH: [Result], LH: [Result], AMH: [Result].
- **Ovulation Confirmation:** Day 21 Progesterone: [Result].
- **Imaging:** Pelvic Ultrasound/HyCoSy: [Summary of findings].
- **Semen Analysis:** [Result/Normal/Awaiting].
- **Infectious Disease Screening:** [HIV/Hep B/Hep C/Rubella status].

Reason for Referral:
Preliminary investigations have not identified a specific cause for the delay in conception. I would appreciate your expert assessment regarding unexplained infertility and a discussion with the patient regarding potential interventions, such as IUI, IVF, or further diagnostic laparoscopy.

Thank you for seeing this patient in your clinic. Please contact my office if you require any further information.

Sincerely,

[Your Name]
[Your Title/Position]
[Clinic/Practice Name]
[Contact Information]