Date: [Date]

To: [Specialist Name]
[Clinic/Department Name]
[Address]

Re: Referral for Fertility Assessment and Consultation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Address: [Patient Address]
Contact Number: [Patient Phone Number]

Dear Dr. [Specialist Last Name],

I am writing to formally refer [Patient Name] for a comprehensive gynecological fertility assessment and consultation.

Clinical History:
The patient has been attempting to conceive for [Duration of Time]. [Briefly mention relevant history: e.g., menstrual cycle regularity, previous pregnancies, known medical conditions, or relevant family history].

Current Investigations:
The following tests have already been performed:

- [Test Name/Date]: [Result]
- [Test Name/Date]: [Result]

Partner Information (if applicable):
[Partner Name/Age/Relevant Test Results].

Reason for Referral:
I would appreciate your expert opinion regarding [specific concerns, e.g., ovulation induction, ovarian reserve testing, or surgical intervention].

Thank you for seeing [Patient Name] and for providing your recommendations for their future management.

Sincerely,

[Doctor Signature]
[Doctor Name]
[Provider Number]
[Clinic Name/Contact Information]