

## **URGENT REFERRAL: BLEEDING DISORDER EVALUATION**

**Date:** [Insert Date]

**To:** [Hematologist Name/Department]

**Facility Name:** [Facility Name]

**Fax/Phone:** [Fax or Phone Number]

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### **RE: PATIENT INFORMATION**

**Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Insurance:** [Insurance Provider & ID Number]

**Contact Number:** [Patient Phone Number]

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Dear Hematology Team,

I am requesting an **urgent** consultation for the above-named patient due to clinical concerns regarding a potential bleeding disorder.

#### **Clinical Reason for Urgency:**

[e.g., Active bleeding, impending emergency surgery, severe thrombocytopenia, or abnormal coagulation profile]

#### **Presenting Symptoms/Findings:**

[Briefly list symptoms, e.g., spontaneous bruising, epistaxis, menorrhagia, or prolonged post-op bleeding]

#### **Relevant Lab Results:**

[PT/INR: Value]

[PTT: Value]

[Platelet Count: Value]

[Other relevant labs: e.g., Fibrinogen, vWF levels]

#### **Current Medications:**

[List any anticoagulants, antiplatelets, or NSAIDs]

Please contact our office at [Your Phone Number] to confirm receipt of this referral and to provide the scheduled appointment time so we may notify the patient.

Thank you for your prompt attention to this matter.

Sincerely,

[Referring Physician Name]

[Practice Name]

[Signature/NPI Number]