Date: [Date]

To: [Referring Physician Name]
Address: [Referring Physician Address]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

Reason for Consultation: Evaluation of bleeding symptoms/abnormal coagulation studies.

History of Present Illness:
[Patient Name] is a [Age]-year-old [Gender] referred for evaluation of [Primary Symptom, e.g., easy bruising, epistaxis, menorrhagia, or post-operative bleeding]. Symptoms began [Timeline].

Bleeding History:

- **Mucosal:** [Epistaxis, gingival bleeding, GI bleeding]
- **Surgical/Traumatic:** [Bleeding after dental extractions, surgeries, or minor injuries]
- **Menstrual (if applicable):** [Duration, frequency, flooding, use of iron]
- **Musculoskeletal:** [History of hemarthrosis or muscle hematomas]

Family History:
[Family history of bleeding disorders, clotting disorders, or consanguinity].

Physical Examination:
General: [Normal/Distress]
Skin: [Petechiae, ecchymosis, telangiectasia, skin hyperextensibility]
Joints: [Hypermobility, evidence of chronic arthropathy]
Lymphatics/Spleen: [Lymphadenopathy or splenomegaly]

Review of Laboratory Data:

- PT/INR: [Value]
- aPTT: [Value]
- Platelet Count: [Value]
- PFA-100: [Value]
- Other: [Factor levels, vWF studies, or Platelet Aggregation if available]

Assessment:
[Diagnosis or Differential Diagnosis, e.g., Von Willebrand Disease, Platelet Function Disorder, Factor Deficiency, or Bleeding of Unknown Etiology].

Plan/Recommendations:

1. **Further Testing:** [Ordered tests: e.g., Factor VIII activity, vWF Antigen, Ristocetin Cofactor, Genetic Testing]
2. **Acute Management:** [DDAVP trial, Antifibrinolytics, or Factor Replacement instructions]
3. **Precautions:** [Avoidance of NSAIDs/Aspirin, activity restrictions]
4. **Follow-up:** [Timeline for next visit]

Sincerely,

[Hematologist Signature]
[Hematologist Name, Credentials]
[Department/Clinic Name]