

Date: [Insert Date]

To: [Recipient Name/Physician Name]

Department: [Department Name, e.g., Hematology/Genetics]

Facility: [Medical Center Name]

Address: [Street Address, City, State, Zip]

RE: Referral for Genetic Screening and Hematology Consultation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Patient ID/MRN: [ID Number]

Dear Dr. [Recipient Last Name],

I am referring this patient to your service for a comprehensive hematology evaluation and genetic screening regarding a suspected bleeding disorder.

Clinical Indication:

The patient presents with the following symptoms and/or history:

- [e.g., Frequent epistaxis or mucosal bleeding]
- [e.g., Excessive bruising without significant trauma]
- [e.g., History of prolonged surgical or dental bleeding]
- [e.g., Family history of Hemophilia, Von Willebrand Disease, or unknown coagulopathy]

Initial Laboratory Findings:

[Insert relevant CBC, PT/INR, PTT, or Platelet count results if available].

Requested Consultation Goals:

- Diagnostic workup for hereditary bleeding disorders.
- Genetic testing and counseling for specific factor deficiencies (e.g., Factor VIII, IX, XI).
- Assessment of Von Willebrand Factor (VWF) activity and multimer analysis.
- Development of a long-term management and/or surgical prophylaxis plan.

Please find the attached medical records and recent laboratory reports. We look forward to your specialist recommendations for this patient.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Credentials]

[Contact Information/Phone Number]