Date: [Insert Date]

To: [Genetic Counselor/Genetics Department Name]
Facility: [Facility Name]
Address: [Facility Address]

RE: Referral for Pediatric Genetic Counseling

Patient Name: [Child's Full Name]
Date of Birth: [DOB]
Parent/Guardian Name: [Parent Name]
Contact Number: [Phone Number]

Dear Genetic Counseling Team,

I am referring this patient for a formal genetic evaluation and counseling. The clinical indications for this referral are as follows:

- **Reason for Referral:** [e.g., Developmental delay, dysmorphic features, family history of genetic disorder, abnormal screening result]
- **Relevant Clinical Findings:** [Insert brief summary of symptoms or physical findings]
- **Current Diagnosis (if any):** [Insert Diagnosis]
- **Specific Concerns/Questions:** [Insert specific questions for the counselor]

Accompanying this letter, please find relevant medical records, growth charts, and previous lab or imaging results. We request that you evaluate the patient and provide recommendations regarding genetic testing and family risk assessment.

Please notify our office of the appointment date or if any further documentation is required.

Sincerely,

Physician Signature: _____

Physician Name: [Name]
Practice Name: [Practice Name]
Phone: [Phone Number]
Fax: [Fax Number]