Date: [Insert Date]

TO: [Specialist Name/Medical Facility]
FROM: [Referring Provider Name and Rank]
SUBJECT: Referral for Specialist Evaluation and Medical Certification

Patient Information:
Name: [Servicemember Full Name]
Rank/Rate: [Rank]
DoD ID Number: [ID Number]
Unit/Command: [Unit Name]

1. Purpose of Referral:
The above-named Servicemember is being referred to your clinic for a formal evaluation regarding [Specific Condition/Diagnosis]. This evaluation is required to determine the member's medical fitness for continued military service and [Specific Duty, e.g., Deployment, Flight Status, Special Operations].

2. Clinical History:
[Provide a brief summary of symptoms, duration, and any treatments attempted to date].

3. Requested Actions:
Please perform a comprehensive assessment and provide a written report addressing the following:

- Confirmation of diagnosis and current severity.
- Recommended treatment plan and expected recovery timeline.
- Impact of the condition on the member's ability to perform physical duties, wear protective equipment, or deploy to austere environments.
- Any permanent or temporary functional limitations.

4. Documentation:
Please ensure all clinical notes and the final certification of fitness are returned to the Primary Care Manager (PCM) or the Medical Readiness Office at [Insert Contact Info/Email/Fax].

Thank you for your assistance in maintaining the medical readiness of this Servicemember.

Sincerely,

[Signature]
[Typed Name and Rank]
[Title/Department]
[Contact Phone Number]