

Date: [Date]
Re: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance Provider/ID: [Policy Information]

To: [Specialist Name/Facility Name]
Address: [Specialist Address]
Phone/Fax: [Specialist Contact Info]

Dear [Specialist Name],

I am writing to formally refer [Patient Name] to your care for evaluation and management of [Specific Condition/Reason for Referral].

Clinical Summary:

[Provide a brief history of the patient's symptoms, duration, and any preliminary findings.]

Current Medications and Allergies:

[List relevant medications and known allergies.]

Recent Diagnostic Results:

[List attached labs, imaging, or test results.]

Care Coordination Goals:

My primary objectives for this referral are [Objective 1, e.g., definitive diagnosis] and [Objective 2, e.g., long-term treatment plan]. Please include me in the care coordination process by sending a consultation report and any recommendations for follow-up care in my office.

If you require further information, please contact my office at [Phone Number]. Thank you for your professional collaboration in the care of this patient.

Sincerely,

[Referring Provider Signature]
[Referring Provider Printed Name]
[Practice/Clinic Name]
[Address]
[Phone/Fax]