Date: [Date]

To: [Consultant Name/Specialty Name]
Facility: [Clinic/Hospital Name]
Address: [Recipient Address]

RE: Patient Referral

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Phone Number: [Patient Phone Number]
Insurance: [Insurance Provider & ID Number]

Dear Dr. [Consultant Last Name],

I am referring this patient to your care for evaluation and management of [Specific Condition or Symptom].

Reason for Referral:
[Briefly describe the clinical reason for the consultation].

Clinical History:
[Summarize relevant history, symptoms, and duration].

Current Medications:
[List medications or note "See attached list"].

Recent Diagnostic Results:
[List relevant labs, imaging, or tests already performed].

Urgency: [Routine / Urgent / Emergent]

Please contact my office at [Your Phone Number] if you require further information. We look forward to receiving your consultation report.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[NPI Number]