

Date: [Date]

To: [Gastroenterologist Name]

Department: Gastroenterology

Facility: [Hospital/Clinic Name]

RE: Referral for [Patient Full Name]

Date of Birth: [DOB]

Address: [Patient Address]

Contact Number: [Patient Phone Number]

Dear Dr. [Gastroenterologist Last Name],

I am referring this patient for a specialist consultation regarding [Main Reason/Symptom, e.g., chronic abdominal pain, suspected IBD, or abnormal LFTs].

Clinical History:

[Provide a brief summary of symptoms, duration, and severity.]

Current Medications:

[List relevant medications]

Pertinent Investigations:

[List relevant blood tests, imaging, or previous scope results]

Specific Request:

I would appreciate your expert opinion and management of this patient. [Optional: Please consider for Colonoscopy/Endoscopy].

Thank you for your assistance in this matter.

Sincerely,

[Doctor Signature]

[Doctor Name]

[Clinic Name]

[Provider Number]

[Contact Email/Phone]