

Date: [Date]

To: [Specialist Name/Practice Name]

Department: [Specialty Department]

Address: [Specialist Address]

RE: Patient Referral

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Parent/Guardian Name: [Guardian Name]

Phone Number: [Contact Number]

Dear Dr. [Specialist Last Name],

I am writing to formally refer [Patient Name] for evaluation and management regarding [Specific Reason for Referral/Diagnosis].

Clinical History:

[Briefly describe symptoms, duration, and relevant developmental history.]

Findings & Diagnostics:

[List relevant physical exam findings, lab results, or imaging performed.]

Current Medications:

[List any relevant medications or allergies.]

Specific Goals for Consultation:

[e.g., Diagnostic clarification, surgical evaluation, or long-term management.]

Please find the attached medical records and test results. We would appreciate being kept informed of your findings and recommended treatment plan.

Sincerely,

[Your Name/Signature]

[Your Medical Title]

[Practice Name]

[Phone Number]

[Fax Number]