Date: [Date]

Recipient Name: [Specialist Name]
Specialty: [Specialty Department]
Clinic/Hospital: [Clinic Name]
Address: [Recipient Address]

RE: Specialist Referral and Transfer of Care

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]
Contact Number: [Patient Phone Number]

Dear Dr. [Specialist Last Name],

I am writing to formally refer [Patient Name] to your care for [Reason for Referral/Specific Condition]. I am also requesting a transfer of clinical responsibility for the ongoing management of this condition.

Clinical History:
[Provide a brief summary of the patient's symptoms, diagnosis, and clinical progress to date.]

Current Medications:
[List current medications and dosages.]

Allergies:
[List known allergies.]

Recent Test Results:
[Mention relevant lab work, imaging, or biopsies attached to this letter.]

Management Plan & Goals:
[Outline what has been done so far and what you expect from the specialist.]

I have discussed this transfer with the patient, and they are in agreement. Please notify my office of the appointment date and provide a consultation report following your assessment.

Thank you for your assistance in the care of this patient.

Sincerely,

[Your Signature]
[Your Printed Name]

[Your Professional Title]
[Your Contact Information/Clinic Name]