**Date:** [Date]

**To:** [Specialist Name/Clinic Name]
**Address:** [Specialist Address]

**From:** [PCP Name/Clinic Name]
**Address:** [PCP Address]
**Phone:** [Phone Number]

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**RE: Referral/Transfer of Care for [Patient Full Name]**
**Date of Birth:** [DOB]
**Insurance Provider:** [Insurance Name/ID]

Dear [Specialist Name/Provider],

I am referring [Patient Name] to your clinic for mental health management. I have been providing primary care for this patient since [Year/Date].

**Reason for Referral:**
[e.g., Management of Major Depressive Disorder, Anxiety, Evaluation for ADHD, etc.]

**Current Clinical Presentation:**
[Briefly describe symptoms and duration]

**Relevant Medical History:**
[List significant medical conditions or comorbidities]

**Current Medications:**
[List psychiatric and non-psychiatric medications]

**Previous Interventions:**
[List past medications tried, therapy history, or hospitalizations]

**Risk Assessment:**
[Note any history of self-harm or suicidal ideation, or state "No acute safety concerns at this time"]

Please find the attached recent clinical notes and lab results. I look forward to your consultation and recommendations for this patient's ongoing care.

Sincerely,

[Signature]
[PCP Name and Credentials]