Date: [Date]

To:
[Receiving Specialist Name]
[Department/Specialty]
[Facility Name]
[Address]

From:
[Referring Clinician Name]
[Facility Name]
[Contact Information]

RE: Transfer of Care / Referral

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

Reason for Referral:

[Briefly describe the clinical reason for the transfer and the specific goals for the specialist consultation.]

Clinical History:

[Summary of patient symptoms, diagnosis, and progression to date.]

Current Medications:

- [Medication 1, Dosage, Frequency]
- [Medication 2, Dosage, Frequency]

Allergies:

[List allergies or "No Known Drug Allergies"]

Investigations and Results:

[List relevant lab results, imaging, or previous tests attached to this referral.]

Management Plan & Recommendations:

[Detail the current treatment and what actions are requested from the receiving specialist.]

Requested Urgency: [Routine / Urgent / Emergent]

Sincerely,

[Signature]
[Printed Name]
[Title/Credentials]