Date: [Date]

To: [Referring Provider Name]
Clinic: [Clinic/Facility Name]
Address: [Clinic Address]

RE: Patient Referral Outcome
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Consultation: [Date of Appointment]

Dear [Referring Provider Name],

Thank you for referring [Patient Name] to our specialty clinic for evaluation of [Condition/Reason for Referral].

Clinical Findings:
Following a comprehensive assessment, the diagnosis has been confirmed as [Diagnosis]. Key findings during the consultation included [Brief Summary of Findings].

Therapy and Treatment Plan:
The following management plan has been initiated:

- **Medication:** [Medication Name, Dosage, and Frequency]
- **Therapeutic Intervention:** [Details of Therapy/Procedures]
- **Lifestyle Recommendations:** [Specific Advice Given]

Follow-Up Actions:
[Patient Name] is scheduled for a follow-up appointment on [Date] to monitor progress. We have requested the following additional tests: [List Tests, e.g., Bloodwork, Imaging].

Required Action for Primary Provider:
[Please continue monitoring BP / Please renew prescription after 3 months / No action required at this time].

Please find the detailed clinical report attached for your records. If you have any questions regarding this therapy plan, please contact our office at [Phone Number].

Sincerely,

[Specialist Name, Title]
[Specialty Department]
[Facility Name]