

**Date:** [Insert Date]

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

**Address:** [Specialist Address]

**Phone/Fax:** [Specialist Phone/Fax]

**RE: Specialist Referral and Pediatric Weight-Based Dosage Authorization**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Date of Birth]

**Current Weight:** [Weight] [kg/lbs] as of [Date Measured]

Dear [Specialist Name],

I am referring the above-named pediatric patient to your care for evaluation and management of [Reason for Referral/Condition].

By way of this letter, I authorize you to prescribe and titrate medications necessary for the treatment of this condition. Please ensure that all pharmacological interventions follow standard pediatric weight-based dosing protocols (e.g., mg/kg).

**Authorization Details:**

- **Scope:** Evaluation and treatment of [Specific Condition].
- **Dosage Guidance:** Calculations must be based on the patient's most recent weight as recorded in your clinical encounter.
- **Duration:** This authorization is valid for [Number] months/years from the date of this letter.

Please provide a summary of your consultation, including any medications prescribed and the weight-based calculations used, via fax to [Primary Care Fax Number].

If you have any questions regarding this referral or the patient's medical history, please contact my office at [Primary Care Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic/Practice Name]

[NPI Number]