Date: [Date]

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

RE: Patient Referral

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

Dear Dr. [Recipient Last Name],

I am writing to formally refer [Patient Name] to your care for [Consultation/Evaluation/Treatment] regarding [Specific Condition or Symptom].

Clinical Reason for Referral:
[Briefly describe the primary concern and clinical goals.]

Medical History & Findings:
[Summarize relevant history, current medications, and any allergies.]

Diagnostic Results:
[List attached labs, imaging reports, or tests.]

Urgency: [Routine / Urgent / Stat]

Please contact our office at [Phone Number] if you require additional documentation or if there are any issues with the scheduling process. We look forward to receiving your consultation report following the visit.

Sincerely,

[Signature]
[Referring Provider Name, Credentials]
[Practice Name]
[Practice Phone/Fax]
[Practice Email]