

# Pediatric Nursing Referral

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**Date:** [Date]

**To (Receiving Provider/Facility):** [Name/Facility Name]  
[Department]  
[Address/Contact Info]

**Patient Information: Name:** [Child's Full Name]  
**DOB:** [MM/DD/YYYY]  
**Guardian:** [Parent/Guardian Name]

Dear [Provider Name],

I am writing to formally refer the above-mentioned pediatric patient for [Specific Nursing Service/Specialty Evaluation]. The patient has been under our care for [Duration of Care] regarding [Primary Diagnosis/Condition].

**Clinical Reason for Referral:**

[Describe current symptoms, clinical needs, or required interventions]

**Current Medications & Treatments:**

[List relevant pediatric medications, dosages, and ongoing therapies]

**Nursing Goals:**

[Detail specific outcomes requested from this referral]

Please find the attached medical records, immunization history, and recent laboratory results for your review.

Sincerely,

[Your Signature]

**Referring Nurse/Provider:** [Full Name and Credentials]  
[Facility Name]  
[Phone Number/Email]