From: [Referring Provider/Consultant Name]
Facility: [Referring Institution]
Contact: [Phone/Email]
Date: [DD/MM/YYYY]

To: [Receiving Consultant/Specialist Name]
Department: [Specialty Department]
Facility: [Receiving Institution]

Patient Identification Name: [Patient Full Name]
DOB: [DD/MM/YYYY]
ID/MRN: [Medical Record Number]

Reason for Referral / Clinical Question

[Primary diagnosis, specific clinical inquiry, or requested intervention]

Clinical Summary & History

[Relevant medical history, current symptoms, and progression]

Current Medications & Allergies

[List current medications and known drug allergies]

Recent Results / Findings

[Summary of pertinent labs, imaging, or previous consultations]

Urgency Level [ ] Routine [ ] Urgent [ ] Emergent

Sincerely,

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Signature of Referring Consultant
Credentials: [MD, DO, NP, PA, etc.]