REFERRING PRACTITIONER INFORMATION

[Referring Doctor Name]

[Clinic Name / Address]

[Phone / Email]

[Date]

RECIPIENT SPECIALIST

[Recipient Name / Title]

[Department / Practice Name]

[Address]

PATIENT DETAILS

Name: [Patient Full Name]

DOB: [Date of Birth]

Contact: [Phone Number]

ID/Insurance: [Policy Number]

REASON FOR REFERRAL / CLINICAL HISTORY

[Insert primary diagnosis, duration of symptoms, and clinical findings]

CURRENT MEDICATIONS & ALLERGIES

[List relevant medications and known contraindications]

URGENCY

[Routine / Urgent / Emergency]

REQUESTED ACTION

[Consultation / Treatment / Diagnostic Testing / Co-management]

Thank you for your expertise in the care of this patient.

SIGNATURE OF REFERRING PRACTITIONER