

**[Sender Name, NP]**  
[Clinic/Facility Name]  
[Address]  
[Phone Number] | [Fax Number]  
[Date]

---

**RECIPIENT:**

[Consultant Name/Specialty Clinic]  
[Facility Name]  
[Address]

**RE: REFERRAL FOR PATIENT:**

**Name:** [Patient Full Name]  
**DOB:** [Date of Birth]  
**Phone:** [Patient Phone Number]

**Reason for Referral:**

*[Insert primary diagnosis, clinical concern, or requested procedure/consultation here]*

**Clinical Summary & Pertinent History:**

*[Brief overview of current symptoms, duration, and relevant medical/surgical history]*

**Current Medications & Allergies:**

*[List relevant medications or attach medication reconciliation list]*

**Attached Documentation:**

- Recent Lab Results
- Imaging/Radiology Reports
- Progress Notes
- Insurance Authorization

Thank you for your expertise and for participating in the care of this patient. Please contact my office at [Phone Number] if further information is required.

Sincerely,

---

**[Sender Name], NP**  
[NPI Number]