

Referring Physician:

[Physician Name & Clinic]

Date:

[DD/MM/YYYY]

To:

[Specialist Name / Department]

Facility:

[Hospital or Specialty Clinic Name]

RE: Patient Referral

Patient Name:

[Full Name]

Date of Birth:

[DD/MM/YYYY]

Parent/Guardian:

[Name & Relationship]

Contact Number:

[Phone Number]

Reason for Referral / Chief Complaint:

[Insert primary clinical concern and duration of symptoms]

Clinical Summary & Pertinent History:

[Relevant medical history, physical exam findings, and current medications]

Diagnostic Tests Performed:

[List labs, imaging, or screenings attached]

Urgency:

Routine Urgent Emergent

Thank you for participating in the care of this patient. Please contact our office at [Phone] if further information is required.

Signature:

NPI Number:

[Number]
