

**REFERRING PHYSICIAN DETAILS**

*[Name, Degree]*

*[Clinic Name]*

*[Address / Contact Information]*

*[Provider ID/NPI Number]*

**DATE**

*[DD/MM/YYYY]*

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**RECIPIENT SPECIALIST**

*[Specialist Name, Degree]*

*[Specialty Department]*

*[Facility/Practice Name]*

**PATIENT INFORMATION**

*Name: [Patient Full Name]*

*DOB: [DD/MM/YYYY]*

*Phone: [Patient Phone Number]*

*Insurance: [Provider & Policy Number]*

**REASON FOR REFERRAL / CLINICAL INDICATION**

*[Brief summary of primary symptoms, suspected diagnosis, or clinical question to be addressed]*

**PERTINENT MEDICAL HISTORY & MEDICATIONS**

*[Relevant chronic conditions, allergies, and current medications]*

**ATTACHMENTS INCLUDED**

*[ ] Lab Results*

*[ ] Imaging/Radiology Reports*

*[ ] Progress Notes*

*[ ] Other: \_\_\_\_\_*

*Sincerely,*

**[Referring Physician Signature]**