Referring Provider: [Name, Title]
Facility: [Clinic/Hospital Name]
Contact: [Phone/Email]

Date: [Current Date]

Receiving Surgeon: [Surgeon Name]
Department: [Surgical Specialty]

RE: Referral for Surgical Consultation

Patient Name: [Full Name]
DOB: [Date of Birth]
Insurance: [Provider / ID Number]

Reason for Referral:
[Primary diagnosis or clinical concern necessitating surgical evaluation]

Clinical Summary:
[Brief history of present illness, relevant physical exam findings, and failed conservative treatments]

Relevant Diagnostics Attached:
- [Imaging: MRI, CT, X-Ray results]
- [Laboratory/Pathology results]
- [Current Medication List]

Urgency: [Routine / Urgent / Emergent]

Please contact our office at [Phone Number] if further documentation is required. We look forward to your specialist assessment and recommendations.

Sincerely,

_____
[Referring Physician Signature]
[NPI Number]