Patient Referral

Date: [Date]

Provider Information

From (APN): [APN Name, Credentials]

Clinic/Facility: [Practice Name]

Contact: [Phone/Fax/Email]

To (Specialist): [Recipient Name/Department]

Organization: [Specialty Clinic Name]

Patient Identification

Patient Name: [Full Name]

DOB: [MM/DD/YYYY]

Phone: [Patient Phone Number]

Insurance: [Provider & ID Number]

Clinical Reason for Referral

Diagnosis/ICD-10: [Primary Diagnosis]

Urgency: [Routine / Urgent / Stat]

Clinical Summary & Specific Concerns:

[Brief history of present illness, relevant physical findings, and specific questions for the specialist]

Supporting Documentation Included

[ ] Recent Lab Results
[ ] Imaging Reports
[ ] Medication List
[ ] Progress Notes

Sincerely,

_____

[APN Name & Signature]
NPI: [NPI Number]