Date:
From: [Referring AGNP Name & Credentials]
Facility/Practice:
Phone/Fax:

To: [Consultant Name/Specialty]
Organization:

Patient Information

Patient Name:
DOB:
Phone:
Insurance/ID:

Reason for Referral / Clinical Question:

[Specific symptoms, geriatric syndromes, or diagnostic clarification requested]

Pertinent Medical History & Comorbidities:

[Chronic conditions, cognitive status, and functional baseline]

Current Medications:

[List medications or attach MAR/Medication Reconciliation]

Urgency: [ ] Routine [ ] Urgent [ ] Telehealth Preferred

Thank you for collaborating on this patient's care. Please forward consultation notes and recommendations to our office via fax.

_____
Signature of Referring Practitioner