

**Date:** [Date]

**From:**

[Referring Provider Name, Credentials]

[Facility Name]

[Contact Information]

**To:**

[Recipient Specialist/Department Name]

[Specialty Clinic/Hospital Name]

[Address]

**Patient Information:**

Name: [Infant Full Name]

DOB: [Date of Birth] | Gestational Age at Birth: [GA]

Guardian: [Parent/Guardian Name]

**Subject:** Referral for Neonatal Specialty Care/Consultation

Dear [Recipient Name],

I am referring the above-named infant for evaluation and management regarding [Specific Reason for Referral/Diagnosis].

**Clinical Summary:**

[Brief history of NICU stay, relevant clinical findings, and current status]

**Current Medications/Support:**

[List respiratory support, nutritional requirements, or medications]

**Specific Concerns/Questions:**

[Outline specific goals for this consultation]

Enclosed please find the patient's recent discharge summary, relevant lab results, and imaging reports. Please contact our office if further documentation is required.

Sincerely,

---

[NNP Signature]

[NNP Printed Name & Certification]