

[Gastroenterology Practice Name]
[Practice Address]
[Phone Number] | [Fax Number]

[Date]

TO: *[Receiving Provider/Specialist Name]*

FACILITY: *[Facility Name]*

FAX: *[Recipient Fax Number]*

RE: PATIENT REFERRAL FOR GASTROENTEROLOGY EVALUATION

PATIENT NAME: *[Patient Full Name]*
DOB: *[MM/DD/YYYY]*
INSURANCE: *[Provider Name & ID Number]*

Dear *[Provider Name]*,

On behalf of *[Referring Provider Name]*, I am referring the above-named patient for evaluation and management of the following:

REASON FOR REFERRAL:

[e.g., GERD, Chronic Abdominal Pain, Screening Colonoscopy, Abnormal LFTs]

CLINICAL BRIEF:

[Brief summary of symptoms, duration, and prior treatments attempted]

Attached to this referral, please find:

- Recent office visit notes
- Relevant lab results (including CBC and Liver Function Tests)
- Imaging reports (Ultrasound/CT/MRI)
- Current medication list and insurance authorization (if required)

Please contact our office at *[Your Phone Number]* if you require additional documentation or once a consultation date has been scheduled.

Thank you for your collaboration in this patient's care.

Sincerely,

[Medical Assistant Name]
Medical Assistant to *[Provider Name]*