

**[Internal Medicine Practice Name]**  
[Practice Address]  
[City, State, Zip Code]  
Phone: [Phone Number] | Fax: [Fax Number]

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**Date:** [Current Date]

**To:** [Recipient Provider Name/Specialty]  
**Facility:** [Recipient Facility Name]  
**Fax:** [Recipient Fax Number]

**RE: Patient Referral**

**Patient Name:** [Patient Full Name]  
**Date of Birth:** [DOB]  
**Insurance:** [Carrier Name] / [ID Number]  
**Authorization #:** [Auth Number, if applicable]

Dear [Provider Name or Department],

On behalf of **Dr. [Referring Physician Name]**, I am referring the above-named patient to your office for [Reason for Referral/Consultation].

**Clinical Summary / Chief Complaint:**  
[Insert brief description of clinical findings or medical necessity]

**Attached Documentation:**  
Recent Progress Notes  
Relevant Lab Results  
Imaging/Radiology Reports  
Current Medication List

Please contact our office at [Phone Number] if you require additional clinical information or if there are issues scheduling the patient. Thank you for participating in the care of this patient.

Sincerely,

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**[Your Name]**  
Medical Assistant to Dr. [Referring Physician Name]