[Referring Clinic/Physician Name]
[Street Address]
[City, State, Zip Code]
[Phone Number] | [Fax Number]

[Date]

TO: [Receiving Specialist/Facility Name]
ATTN: [Department/Provider Name]
FAX: [Recipient Fax Number]

RE: Patient Referral
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Phone: [Patient Phone Number]
Insurance: [Provider Name] | **ID:** [Policy Number]

REASON FOR REFERRAL: [E.g., High-Risk Pregnancy Consultation, Gynecological Surgery, Abnormal Imaging]

Clinical Indications / Diagnosis:
[Brief summary of clinical findings, ICD-10 codes, and urgency level]

Requested Services:
[ ] Consultation and Treatment
[ ] Diagnostic Evaluation Only
[ ] Second Opinion
[ ] Surgical Evaluation

Attachments Included:
[ ] Recent Lab Results (HCG, CBC, UA)
[ ] Imaging Reports (Ultrasound/Mammogram/MRI)
[ ] Clinical Progress Notes
[ ] Insurance Authorization/Referral Form

Please contact our office at [Phone Number] if further information is required or to confirm receipt of this referral. We request a copy of your consultation notes and any recommended treatment plan following the patient's visit.

Sincerely,

_____
[Medical Assistant Name]
On behalf of **[Referring Physician Name, M.D./D.O.]**