

[Clinic Name] - Orthopedic Department

[Street Address]

[City, State, Zip Code]

[Phone Number] | [Fax Number]

Date:

TO:

CLINIC/FACILITY:

FAX:

RE: PATIENT REFERRAL

Patient Name:

Date of Birth:

Insurance Provider:

Authorization #:

Dear ,

On behalf of **Dr.** , I am referring the above-named patient to your office for consultation and management regarding the following orthopedic concern:

Diagnosis/Reason for Referral:

Attached Documentation:

- Patient Demographics & Insurance Card
- Recent Orthopedic Progress Notes
- Imaging Reports (X-Ray / MRI / CT)
- Current Medication List

Please contact our office once the appointment has been scheduled or if additional clinical information is required. We look forward to receiving your consultation report.

Sincerely,

[Medical Assistant Name]

Orthopedic Medical Assistant to Dr. [Physician Name]