[Consultant Pharmacist Name/Practice]
[Professional Title/Credentials]
[Address Line 1]
[City, State, Zip Code]
[Phone Number] | [Email Address]

[Date]

TO: [Recipient Physician/Provider Name]
FACILITY: [Clinic/Hospital Name]
RE: [Patient Full Name]
DOB: [Patient Date of Birth]

Dear [Recipient Name],

I am referring the above-named patient to your care for **[Reason for Referral/Specialty Consultation]**. Following a comprehensive clinical medication review conducted on [Date], I have identified specific areas requiring your specialized diagnostic or therapeutic intervention.

Clinical Findings & Rationales:

- [Summary of identified medication-related problem or clinical observation]
- [Relevant lab values or vital signs, if applicable]
- [Current pharmacological barriers or contraindications]

Current Medication Profile Highlights:

[List pertinent medications or attach full Medication Administration Record (MAR)]

Consultant Recommendations:

[Proposed clinical action or adjustment for physician consideration]

Please find the attached full Medication Therapy Management (MTM) report and relevant clinical notes for your review. I am available to discuss this case further at your convenience.

Sincerely,

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[Consultant Pharmacist Name, Credentials]
[License Number/NPI]