

DOCTOR REFERRAL LETTER

Referring Physician Name: _____

Referring Physician Address: _____

Referring Physician Phone/Email: _____

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Phone/Email: _____

Referred Specialist Information:

Specialist Name: _____

Specialty: _____

Address: _____

Phone/Email: _____

Clinical Information:

Reason for Referral:

The patient is referred for specialized evaluation and/or management in the area of expertise provided by the receiving specialist. The referring physician has provided initial evaluation, diagnosis, and treatment as appropriate.

Relevant Medical History and Findings:

Please review the attached medical records, diagnostic tests, and clinical notes for detailed history and findings pertinent to this referral.

Specific Questions or Issues to Address:

The referring physician requests that the specialist evaluate the patient for further diagnostic workup, therapeutic interventions, or procedural considerations as clinically indicated.

Attachments:

The following documents are included with this referral:

- Relevant medical records
- Laboratory and imaging results
- Medication list
- Prior consultation notes

Authorization and Legal Compliance:

The referring physician affirms that the referral is made in good faith and in accordance with applicable laws and regulations governing patient privacy and medical practice in the United States. Patient consent has been obtained for the release of medical information as required by HIPAA and relevant state laws. The specialist is authorized to provide evaluation and treatment as clinically indicated.

Signatures:

Referring Physician Signature

Specialist Acknowledgment

Signature: _____

Signature: _____

Printed Name: _____

Printed Name: _____

Date: _____

Date: _____

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