

Medical Referral Request for Diagnostic Testing

Date: [Insert Date]

To: [Specialist's Name]

[Specialist's Address]

[City, State, Zip Code]

From: [Your Name]

[Your Practice Name]

[Your Address]

[City, State, Zip Code]

Dear [Specialist's Name],

I am writing to refer my patient, [Patient's Name], for diagnostic testing due to [brief description of the medical issue or symptoms]. After a thorough evaluation, I believe that [he/she/they] may benefit from [specify tests needed, e.g., MRI, CT scan, blood tests, etc.].

Patient information:

- Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Contact Number: [Patient's Phone Number]
- Insurance Information: [Patient's Insurance Details]

Please find attached [any relevant medical history, lab results, or other documents] for your reference.

Thank you for your attention to this matter. If you have any questions or require further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

[Your Name]

[Your Title]

[Your Practice Name]