Medical Referral Request for Pediatric Care

Date: [Insert Date]

To: [Pediatric Specialist's Name] [Pediatric Specialist's Clinic Name] [Clinic Address] [City, State, Zip Code]

Dear [Pediatric Specialist's Name],

I am writing to refer my patient, [Patient's Full Name], a [Patient's Age] year old [Male/Female], for further evaluation and management of [specific medical condition or symptoms].

Patient History:

- Patient ID: [Insert Patient ID]
- Medical History: [Brief Summary of Medical History]
- Current Medications: [List Medications]
- Allergies: [List Allergies]

Reason for Referral:

[Detailed description of the reason for referral, including any relevant examination findings or test results that support the need for specialist care.]

Please find enclosed copies of the patient's medical records and any relevant imaging studies.

If you have any questions or require additional information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this referral.

Sincerely,

[Your Name] [Your Title/Position] [Medical Practice Name] [Practice Address] [City, State, Zip Code] [Your Phone Number] [Your Email Address]