Medical Referral Request for Surgical Assessment

Date: [Insert Date]

To: [Surgeon's Name]
[Surgeon's Clinic/Hospital Name]
[Clinic/Hospital Address]
[City, State, Zip Code]

Dear [Surgeon's Name],

I am writing to refer my patient, [Patient's Full Name], age [Patient's Age], who is experiencing [brief description of the medical condition]. After a thorough evaluation, I believe that a surgical assessment is necessary for [his/her/their] condition.

Patient's Medical History:

- Diagnosis: [Insert Diagnosis]
- Relevant Medical History: [Briefly outline medical history]
- Current Medications: [List of medications]
- Previous Treatments: [Outline previous treatments]

Given the patient's ongoing symptoms of [briefly state symptoms], I believe that [he/she/they] would benefit from a surgical assessment to determine the best course of treatment.

Please let me know if you require any additional information or documentation. I appreciate your attention to this referral and look forward to your evaluation and recommendations.

Thank you for your assistance.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Clinic/Hospital Name]
[Your Contact Information]