Referral for Swallowing and Feeding Therapy

Date: [Insert Date]

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

Dear [Therapist's Name],

I am writing to refer my patient, [Patient's Full Name], a [Patient's Age] year-old [Gender], for evaluation and treatment of swallowing and feeding difficulties. [He/She/They] has been experiencing [brief description of symptoms and duration, e.g., difficulty swallowing, choking during meals, or refusal to eat].

Relevant medical history includes [briefly include any significant medical history, diagnoses, or treatments]. [Patient's Name] is currently taking the following medications: [list medications].

On initial examination, I have noted [describe any observations, e.g., weight loss, aspiration risk, or specific feeding issues]. I believe that a thorough assessment by your team would be beneficial to address these concerns.

Please find attached [mention any relevant documents, e.g., medical history, assessment notes, or reports]. I would appreciate your insights and recommendations regarding [Patient's Name]'s condition.

Thank you for your attention to this matter. If you have any questions or require further information, feel free to contact me at [Your Phone Number] or [Your Email Address].

Sincerely,

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