# Patient Referral for Gastroenterology Services

[Your Name]

[Your Title]

[Your Practice Name]

[Your Address]

[City, State, Zip Code]

[Phone Number]

[Email Address]

[Date]

Dr. [Gastroenterologist's Name]

[Gastroenterologist's Practice Name]

[Gastroenterologist's Address]

[City, State, Zip Code]

Dear Dr. [Gastroenterologist's Last Name],

I am referring my patient, [Patient's Name], born on [Date of Birth], for evaluation and management of gastrointestinal concerns. [He/She/They] has been experiencing [brief description of symptoms or issues] over the past [duration].

Relevant medical history includes:

- [Medical Condition 1]
- [Medical Condition 2]
- [Previous Treatments or Surgeries]

The patient is currently taking the following medications:

- [Medication 1]
- [Medication 2]

Attached are the patient's medical records for your review. I believe a consultation would be beneficial to further assess [his/her/their] condition and management options.

Thank you for your attention to this referral. Please feel free to contact me if you need any additional information.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

[Your Practice Name]