

Dermatology Referral Letter

Date: [Insert Date]

Referring Physician: [Physician Name]

Referring Physician Address:

[Address Line 1]

[Address Line 2]

[City, State, Zip]

To: [Dermatologist Name]

Dermatology Clinic: [Clinic Name]

[Clinic Address Line 1]

[Clinic Address Line 2]

[City, State, Zip]

Patient Information:

Patient Name: [Patient Name]

Date of Birth: [DOB]

Address: [Patient Address]

Phone Number: [Patient Phone Number]

Referral Reason:

I am referring the above-named patient for evaluation and management of suspected fungal skin infections.

Clinical Findings:

[Brief description of symptoms, duration, affected areas]

[Previous treatments and their outcomes]

Required Actions:

Please evaluate the patient for potential dermatophyte or yeast infections and recommend appropriate treatment.

Additional Information:

If you need further information, please do not hesitate to contact me at [Referring Physician Phone Number] or [Referring Physician Email].

Thank you for your assistance in managing this patient's care.

Sincerely,

[Referring Physician Name]

[Referring Physician Signature]

[Referring Physician License Number]