

# Patient Referral for Surgical Evaluation

Date: [Insert Date]

To: [Surgeon's Name]  
[Surgeon's Title]  
[Hospital/Clinic Name]  
[Address Line 1]  
[City, State, ZIP Code]

Dear [Surgeon's Name],

I am writing to refer my patient, [Patient's Name], who is a [Age] year old [Gender] with a medical history of [Relevant Medical History] for surgical evaluation. The patient presents with [Brief Description of Symptoms/Condition].

After conducting a thorough examination and considering the patient's current condition, I believe that a surgical evaluation may be necessary due to [Reason for Referral].

Enclosed are the patient's relevant medical records, including [List of Records or Tests], to assist in your assessment.

Please feel free to contact me should you need any further information or clarification regarding this referral. I appreciate your expertise in evaluating this patient.

Thank you for your attention to this matter.

Sincerely,

[Your Name]  
[Your Title]  
[Your Practice Name]  
[Your Contact Information]