Specialist Referral Authorization

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Date of Birth: [Insert DOB]

Patient ID: [Insert Patient ID]

Referring Physician: [Insert Physician Name]

Referring Physician Contact: [Insert Contact Information]

Specialist Details

Specialist Name: [Insert Specialist Name]

Specialty: [Insert Specialty]

Contact Information: [Insert Contact Information]

Referral Purpose

The purpose of this referral is for diagnostic testing related to [Insert specific condition or symptoms].

Requested Diagnostic Tests

- [Insert Test 1]
- [Insert Test 2]
- [Insert Test 3]

Authorization Statement

I, [Insert Physician Name], authorize the aforementioned tests to be performed for the patient listed above.

Signature: _____

Date: _____