Referral Authorization for Orthopedic Evaluation

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

Patient Date of Birth: [Insert DOB]

Insurance Information: [Insert Insurance Details]

To: [Orthopedic Specialist's Name]
[Orthopedic Practice Name]
[Practice Address]
[City, State, Zip Code]

Dear [Orthopedic Specialist's Name],

I am writing to authorize a referral for my patient, [Patient Name], for an orthopedic evaluation. After reviewing the patient's medical history and current condition, I believe a detailed assessment by a specialist in orthopedics is necessary.

Reason for Referral:

[Brief description of the patient's condition, symptoms, and any relevant tests performed]

Please perform a comprehensive evaluation of the patient, and feel free to conduct any necessary diagnostic imaging or tests. I would appreciate your insights on the most effective treatment options moving forward.

Thank you for your attention to this matter.

Sincerely,
[Your Name]
[Your Title/Position]
[Your Practice Name]
[Your Phone Number]
[Your Email Address]