Orthopedic Consultation Referral

Referring Physician: Dr. John Smith, MD

Practice Name: Downtown Medical Clinic

Address: 123 Main St, Suite 100, Anytown, ST 12345

Phone: (555) 123-4567

Date: [Date]

To: Dr. Jane Doe, MD

Specialty: Orthopedic Surgery

Practice Name: Anytown Orthopedic Clinic

Address: 456 Elm St, Anytown, ST 12345

Phone: (555) 765-4321

Patient Information

Patient Name: [Patient Name]

DOB: [Date of Birth]

Gender: [Gender]

Insurance: [Insurance Provider]

Reason for Referral

[Brief description of wrist and hand injuries, including symptoms, duration, and any prior treatments or interventions.]

Current Medications

[List of current medications, if applicable]

Additional Notes

[Any additional relevant information or special considerations]

Thank you for your assistance with this patient.

Sincerely,

Dr. John Smith, MD

[Signature if needed]