**Referring Doctor Information:**

* Referring Doctor's Name:
* Medical License Number:
* Clinic or Practice Name:
* Address:
* Phone Number:
* Email:

**Patient Information:**

* Patient's Full Name:
* Date of Birth:
* Gender:
* Address:
* Phone Number:
* Email:

**Reason for Referral:**

* **Describe the medical condition or reason for the referral:**

**Preferred Provider Information:**

* Provider's Name (Specialist or Facility):
* Provider's Specialty:
* Address:
* Phone Number:
* Email:

**Preferred Appointment Date and Time:**

* **Date:**
* **Time:**

**Patient's Medical History and Relevant Information:**

* **Summary of the patient's medical history, relevant test results, and treatment to date:**

**Medications:**

* **List of current medications (include names and dosages):**

**Allergies:**

* **List any known allergies (medications, environmental, food, etc.):**

**Additional Instructions or Comments:**

* **Include any specific instructions or additional information for the referred provider:**

**Patient Consent:**

* I, the undersigned, consent to the referral and release of my medical information to the referred provider.
* Patient's Signature:
* Date:

**Referring Doctor's Notes:**

* **Provide any additional notes, comments, or observations relevant to the referral:**

**Signature of Referring Doctor:**

* **Referring Doctor's Signature:**
* **Date:**