

Gastroenterology Specialist Consultation Referral Letter

Referring Doctor:

Name: _____

Clinic/Hospital: _____

Phone: _____

Email: _____

Date:

____ / ____ / _____

Patient Details

Name: _____

Date of Birth: ____ / ____ / _____

Gender: _____

Medical Record No.: _____

Phone: _____

Diagnosis/Suspected Condition

Reason for Referral

Relevant Medical History

Current Medications & Allergies

Relevant Findings/Investigations (labs, imaging, etc.)

Special Notes/Instructions

Referring Doctor's Signature:
