

Continuity and Coordination of Care

Primary Care Physician to Specialist



To: Specialist _____

From: PCP _____

RE: Patient Name _____ D.O.B. _____

I am providing you with the following information to assist you in the treatment of my patient.

Diagnosis/Reason for Referral: _____

Past History: _____

Other pertinent diagnostic findings (with attachments if needed): _____

Medications: _____ Allergies/Adverse Reactions: NKA

Other physicians involved in patient's care: _____

Additional Comments: _____

Please mail or fax this information to:

Name: _____

Address: _____

Fax: _____

Sincerely,

(Signature of Primary Care Physician)