[Your Name]
[Your Title]
[Your Practice/Clinic Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Recipient's Name]
[Recipient's Title]
[QD Medical]
[Recipient's Address]
[City, State, Zip Code]

Dear [Recipient's Name],

I am writing to refer my patient, [Patient's Full Name], who is [age] years old, for [specific reason for referral, e.g., further evaluation, treatment, diagnostic testing, etc.].

Patient History:

- Medical History: [Brief overview of pertinent medical history]
- Current Medications: [List current medications]
- Allergies: [List known allergies]

Clinical Findings:

- [Brief summary of relevant clinical findings or symptoms]
- [Any relevant test results or imaging]

Given the complexity of [Patient's condition/issue], I believe that [QD Medical] can provide the specialized care that is essential for [Patient's Full Name].

Please find attached copies of relevant medical records for your review. I would appreciate your expertise in evaluating and managing [Patient's condition].

Feel free to contact me at [Your Phone Number] or [Your Email Address] if you need further information or to discuss this case.

Thank you for your attention and assistance.

Sincerely,

[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Title]
[Your Practice/Clinic Name]