

Date: [Date of Consultation]

Referring Provider: [Referring Physician Name]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Consultation Type: Synchronous Audio-Visual Telehealth

RE: Skin Lesion Evaluation

Reason for Consultation:

Evaluation of a [Location, e.g., right forearm] skin lesion, first noted by the patient [Timeframe].

History of Present Illness:

The patient reports the lesion is [Asymptomatic / Itchy / Painful / Bleeding]. They note [Changes in size / Changes in color / No changes]. No personal history of skin cancer. Family history is [Positive/Negative] for melanoma.

Visual Examination (via High-Resolution Image/Video):

Location: [Specific Anatomical Site]

Description: [Size in mm] [Color] [Macule/Papule/Nodule] with [Regular/Irregular] borders. No visible ulceration or crusting noted on digital images provided.

Assessment:

1. [Primary Diagnosis or Differential Diagnosis, e.g., Benign Nevus vs. Seborrheic Keratosis]
2. [Secondary Assessment, e.g., Actinic Keratosis]

Plan/Recommendations:

- **Clinical Action:** [e.g., Clinical monitoring / Referral for in-person shave biopsy / Topical treatment]
- **Patient Education:** Counseled on ABCDEs of melanoma and sun protection (SPF 30+).
- **Follow-up:** Return to clinic in [Number] months or sooner if the lesion changes.

Telehealth Limitation Note:

This evaluation was performed via telehealth. Physical palpation and dermoscopy were not possible. If the lesion evolves or fails to respond to treatment, an in-person evaluation is required.

Sincerely,

[Provider Signature]

[Provider Name, Title]

[Medical License Number]