

**Date:** [Date]

**To:** [Referring Physician Name]

**Facility:** [Referring Institution]

**Address:** [Street Address, City, State, Zip]

**RE:** Second Opinion Consultation

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Diagnosis:** [Primary Diagnosis/ICD Code]

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## 1. Reason for Consultation

[Briefly state why the patient requested a second opinion and the specific clinical questions to be addressed.]

## 2. Clinical History & Review of Records

**History of Present Illness:** [Summary of symptoms, onset, and progression.]

**Diagnostic Workup:** [Review of imaging, such as CT/PET/MRI scans, and laboratory results.]

**Pathology Review:** [Summary of biopsy results, histology, and molecular/genetic markers.]

**Prior Treatments:** [Summary of previous surgeries, chemotherapy cycles, or radiation therapy.]

## 3. Physical Examination

[Document pertinent physical findings, performance status (ECOG/Karnofsky), and vital signs.]

## 4. Impression and Assessment

[Your expert clinical assessment of the current stage and status of the malignancy.]

## 5. Recommendations and Proposed Treatment Plan

- **Recommended Therapy:** [Details of recommended chemotherapy, immunotherapy, surgery, or radiation.]
- **Alternative Options:** [Discussion of other viable treatment paths.]
- **Clinical Trials:** [Eligibility for ongoing clinical trials if applicable.]
- **Supportive Care:** [Pain management, nutritional support, or psychological resources.]

## 6. Follow-up and Coordination of Care

[Plan for ongoing management and how the consulting physician will collaborate with the primary oncologist.]

Sincerely,

[Signature]

**[Consulting Physician Name, MD/DO]**

[Oncology Sub-specialty]

[Contact Information]