

[Date]  
[Referring Physician Name]  
[Clinic/Hospital Name]  
[Address]

**RE: [Patient Name]**  
DOB: [Date of Birth]  
Parent/Guardian: [Name]

Dear Dr. [Referring Physician Last Name],

Thank you for requesting a pediatric orthopedic surgical consultation for [Patient Name] regarding [Primary Complaint/Diagnosis].

**Clinical History:**

[Patient Name] presents with a [Number]-month/year history of [Symptoms]. The symptoms are localized to the [Left/Right/Bilateral] [Body Part]. Previous treatments include [Physical Therapy/Bracing/Medication].

**Physical Examination:**

The patient is a well-developed, well-nourished child in no acute distress. Focused examination of the [Affected Area] reveals:

- Range of Motion: [Details]
- Stability: [Details]
- Neurovascular Status: [Intact/Deficits]
- Gait Analysis: [Details]

**Imaging and Diagnostics:**

X-rays/MRI dated [Date] demonstrate [Findings, e.g., Physeal involvement, angulation, or dysplasia].

**Assessment:**

[Diagnosis and ICD-10 Code]. Given the [Skeletal Immaturity/Severity of Deformity], surgical intervention is recommended to [Objective, e.g., Restore alignment/Stabilize joint].

**Plan:**

The risks, benefits, and alternatives of [Procedure Name] were discussed with the family. We plan to proceed with surgery on [Date]. Post-operative care will involve [Bracing/Cast/Non-weight bearing] for [Duration].

I will update you following the procedure. Please contact my office if you have any questions.

Sincerely,

[Your Signature/Name]  
Pediatric Orthopedic Surgeon  
[Medical License Number]