

**DATE:** [Date of Letter]

**RE:** Orthopedic Surgical Consultation  
**PATIENT NAME:** [Patient Full Name]  
**DATE OF BIRTH:** [DOB]  
**CLAIM NUMBER:** [Claim #]  
**DATE OF INJURY:** [DOI]  
**EMPLOYER:** [Employer Name]

**TO:** [Claims Adjuster/Insurance Carrier Name]  
**ATTN:** [Adjuster Name or Case Manager]

Dear [Adjuster Name],

**I. HISTORY OF PRESENT ILLNESS:**

The patient is a [Age]-year-old [Gender] who sustained an injury to their [Body Part, e.g., Right Knee] on [Date] while performing [Job Task]. The mechanism of injury involved [Brief Description of Accident]. The patient currently complains of [Symptoms, e.g., sharp pain, instability, numbness].

**II. PHYSICAL EXAMINATION:**

Clinical examination of the [Body Part] reveals: [Findings, e.g., localized tenderness, restricted range of motion, positive orthopedic tests].

**III. DIAGNOSTIC IMAGING:**

Review of [X-ray/MRI/CT Scan] dated [Date] demonstrates: [Key Findings].

**IV. DIAGNOSIS:**

1. [Primary Diagnosis/ICD-10 Code]
2. [Secondary Diagnosis]

**V. CAUSAL RELATIONSHIP:**

Based on the history provided and clinical findings, it is my professional medical opinion that the diagnosed condition is directly related to the work-related accident that occurred on [Date of Injury].

**VI. TREATMENT PLAN & SURGICAL RECOMMENDATION:**

The patient has failed conservative treatment, including [Physical Therapy/Injections/Medication]. I am recommending the following surgical intervention:

**Procedure:** [Name of Surgery, e.g., Arthroscopic Meniscectomy]

**CPT Code(s):** [List Codes]

**VII. WORK STATUS:**

- [ ] Patient may return to work with the following restrictions: [List Restrictions]
- [ ] Patient is Temporarily Totally Disabled (TTD) pending surgery.

Please provide authorization for the recommended procedure at your earliest convenience.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[Phone Number]