

Date: [Date]

Recipient Name: [Referring Physician Name]

Address: [Clinic Address]

City, State, Zip: [City, State, Zip]

RE: [Patient Name]

DOB: [Date of Birth]

Date of Injury: [Date of Injury]

Dear [Referring Physician Name],

Thank you for requesting an orthopedic consultation for [Patient Name] regarding a suspected [Location of Fracture, e.g., distal radius] fracture.

History of Present Illness:

The patient is a [Age]-year-old [Gender] who presents following a [Mechanism of injury, e.g., fall on outstretched hand]. The patient reports pain, swelling, and [mention any numbness or weakness] in the affected area.

Physical Examination:

Examination of the [Left/Right] [Body Part] reveals significant tenderness over the [Specific Bone/Area]. There is [mild/moderate/severe] swelling and ecchymosis. Neurovascular status is intact distally with palpable pulses and normal capillary refill. Range of motion is limited by pain.

Imaging:

X-rays of the [Body Part] obtained on [Date] demonstrate a [Type of fracture, e.g., displaced, comminuted, or non-displaced] fracture of the [Specific Bone].

Assessment:

[Diagnosis, e.g., Closed fracture of the distal end of right radius].

Plan:

1. **Reduction:** [e.g., Closed reduction performed in clinic / Not required].
2. **Immobilization:** [e.g., Short arm fiberglass cast applied / Splint applied].
3. **Activity:** [e.g., Non-weight bearing / Strict elevation / Ice therapy].
4. **Follow-up:** The patient will return in [Number] weeks for repeat imaging and clinical reassessment.

If there are any changes in neurovascular status, the patient has been instructed to seek immediate emergency care.

Sincerely,

[Your Name, MD/DO]
[Orthopedic Surgery]
[Phone Number]