Date: [Date]
To: [Referring Physician Name]
Address: [Physician Address]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Procedure: Radiofrequency Ablation (RFA) Consultation

Dear Dr. [Physician Last Name],

Thank you for referring [Patient Name] for an interventional consultation regarding Radiofrequency Ablation (RFA) for the management of [Diagnosis/Condition, e.g., chronic low back pain or hepatic lesion].

Clinical History:
The patient presents with a [Number]-month history of [Symptoms]. Previous conservative treatments, including [List treatments, e.g., physical therapy or medications], have provided sub-optimal relief. Imaging studies dated [Date] demonstrate [Key findings from MRI/CT/Ultrasound].

Evaluation:
On physical examination, the patient exhibits [Key physical findings]. Based on the clinical presentation and diagnostic imaging, the patient appears to be an appropriate candidate for Radiofrequency Ablation targeted at [Specific Anatomical Site].

Plan:
I have discussed the RFA procedure in detail with the patient, including the risks, benefits, and expected outcomes. The patient has expressed a desire to proceed. We have scheduled the procedure for [Date/Time] at [Facility Name].

Follow-up:
A post-procedure evaluation will be scheduled for [Timeline, e.g., 2 weeks] following the intervention. I will provide a formal procedure report and follow-up summary once completed.

Please feel free to contact my office if you have any questions or require additional information.

Sincerely,

[Your Name, MD/DO]
[Department/Specialty]
[Contact Information]