

Date: [Date]

Referring Physician: [Referring Physician Name]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Date of Evaluation: [Date of Evaluation]

RE: Interventional Radiology Consultation for Kyphoplasty

History of Present Illness:

The patient is a [Age]-year-old [Male/Female] referred for evaluation of painful vertebral compression fracture(s) located at [Level, e.g., T12, L1]. The pain began on [Onset Date] following [Mechanism of Injury/Spontaneous onset]. The patient describes the pain as [Description of pain] and rates it a [Score]/10. Conservative management, including [Analgesics/Bracing/Physical Therapy], has failed to provide adequate relief.

Physical Examination:

On examination, there is point tenderness over the [Vertebral Level] spinous process. Neurological exam reveals [Normal strength and sensation/Specific deficits]. There are no signs of myelopathy or radiculopathy.

Imaging Review:

[MRI/CT/X-ray] dated [Date] demonstrates a [Acute/Subacute] compression fracture at [Level] with approximately [Percentage]% height loss. [Edema on STIR sequences/Increased uptake on Bone Scan] confirms the chronicity and acuity of the fracture at this level.

Assessment:

The patient has a symptomatic vertebral compression fracture at [Level] that correlates with clinical symptoms and physical findings. The patient meets the criteria for Kyphoplasty to stabilize the fracture, reduce pain, and restore vertebral height.

Plan:

The risks, benefits, and alternatives of the Kyphoplasty procedure were discussed, including bleeding, infection, cement extravasation, and nerve injury. The patient has consented to proceed. The procedure is scheduled for [Date/Time].

Thank you for this referral.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Department of Interventional Radiology]