

**Date:** [Insert Date]

**RE:** [Patient Name]

**DOB:** [Patient Date of Birth]

**ID Number:** [Patient Medical Record Number]

**To:** [Referring Physician Name]

**Reason for Consultation:** Evaluation of suspected infectious process with unknown pathogen/fever of unknown origin.

**History of Present Illness:**

[Patient Name] is a [Age]-year-old [Gender] presenting with [Duration] of [Primary Symptom, e.g., persistent fever]. Associated symptoms include [List symptoms like rash, weight loss, or lymphadenopathy]. Previous treatments include [List prior antibiotics or medications] with [Result].

**Relevant History:**

- Birth/Immunization History: [Details]
- Exposure History: [Travel, animals, sick contacts, unpasteurized dairy]
- Past Medical History: [Chronic conditions, surgeries]

**Physical Examination:**

- Vitals: [Temp, HR, RR, BP]
- General: [Appearing ill/toxic/well]
- Significant Findings: [HEENT, Lungs, Heart, Abdomen, Skin/Rash, Lymph nodes, Musculoskeletal]

**Diagnostic Evaluation to Date:**

- Imaging: [Results of X-ray, CT, MRI, Ultrasound]
- Laboratory: [WBC, CRP/ESR, Blood cultures, Respiratory panels]

**Assessment and Differential Diagnosis:**

At this time, the etiology of the patient's symptoms remains unidentified. Our differential diagnosis includes:

1. Atypical bacterial infection (e.g., Bartonella, Mycobacteria)
2. Viral syndrome (e.g., EBV, CMV, Adenovirus)
3. Non-infectious inflammatory process (e.g., Kawasaki disease, MIS-C, JIA)
4. Fungal or parasitic infection

**Recommendations and Plan:**

- [Order specific advanced serology or PCR testing]
- [Order repeat cultures or tissue biopsy]
- [Start/Adjust/Discontinue specific antimicrobial therapy]
- [Follow-up appointment details]

Thank you for the opportunity to participate in the care of this patient.

Sincerely,

[Consulting Physician Name], MD/DO  
Pediatric Infectious Disease  
[Contact Information]