Date: [Insert Date]

To: [Referring Physician Name]
Address: [Referring Physician Address]
Fax/Phone: [Referring Physician Contact]

RE: Patient Name: [Patient Full Name]
DOB: [Patient Date of Birth]
Surgical Procedure: [e.g., CABG / Lower Extremity Bypass / AV Fistula Creation]

Dear Dr. [Referring Physician Last Name],

At your request, I evaluated [Patient Name] on [Date of Evaluation] for preoperative vein mapping to assist in surgical planning for [Proposed Procedure].

Clinical Indications:
The patient requires assessment of venous conduits to ensure adequate size, patency, and anatomical suitability for use as a surgical graft.

Imaging Findings:
Duplex ultrasound mapping was performed on the [Right/Left/Both] [Upper/Lower] extremities. The findings are as follows:

- **Superficial System:** [e.g., Great Saphenous Vein is patent with a diameter of X mm at the thigh.]
- **Deep System:** [e.g., Deep veins are compressible and free of thrombus.]
- **Anatomic Variations:** [e.g., No bifurcations or abnormalities noted.]

Impression:
[Summary of findings, e.g., The Great Saphenous Vein is suitable for harvesting.]

Recommendations:
Based on these findings, we recommend [e.g., proceeding with surgery as planned / considering alternative conduits due to small vessel diameter].

Detailed ultrasound reports and images are attached for your review. Please contact our office at [Your Phone Number] if you have any questions regarding these results.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Practice Name]