

[Your Name/Practice Name]

[Your Address]

[City, State, Zip Code]

[Phone Number]

[Date]

[Consultant Name]

[Department of Plastic and Reconstructive Surgery]

[Hospital/Clinic Name]

[Address]

[City, State, Zip Code]

**RE: Referral for Reconstructive Surgery Consultation**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Patient ID/MRN:** [ID Number]

Dear Dr. [Consultant Last Name],

I am writing to formally refer this patient for a reconstructive plastic surgery consultation regarding [specific condition, e.g., post-mastectomy reconstruction, scar revision, post-traumatic deformity].

**Clinical History:**

[Provide a brief summary of the patient's medical history, the primary diagnosis, and any previous treatments or surgeries related to this concern.]

**Current Findings:**

[Describe the physical findings, functional impairments, or aesthetic concerns that necessitate reconstruction.]

**Goal of Referral:**

The objective of this referral is to [e.g., assess suitability for surgical intervention, restore function, or improve anatomical symmetry].

**Relevant Medical Conditions:**

[List significant comorbidities, medications, or allergies.]

I have attached [list any attached reports, such as imaging, pathology, or previous operative notes] for your review. Please contact my office if you require any further information.

Thank you for your expertise in the care of this patient.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Credentials]