Date: [Date]

RE: [Patient Full Name]
DOB: [Patient Date of Birth]
Date of Consultation: [Date of Visit]

To Dr. [PCP Last Name],

I had the pleasure of seeing your patient, [Patient Name], in reconstructive consultation regarding [Reason for Referral/Diagnosis: e.g., post-mastectomy defect, traumatic scar, or functional deficit].

Clinical Findings:
Upon evaluation, the patient presents with [Brief description of physical findings]. They report symptoms of [Pain/functional limitation/distress] related to this condition. We discussed the impact on their quality of life and activities of daily living.

Proposed Plan:
After reviewing the surgical and non-surgical options, we have decided to proceed with [Name of Procedure: e.g., Tissue Expander Placement, Scar Revision, or Flap Reconstruction]. This procedure is scheduled for [Date, if applicable] at [Facility Name].

Pre-operative Requirements:
To ensure the patient is optimized for surgery, I kindly request the following from your office:
[ ] Pre-operative history and physical clearance
[ ] Recent EKG
[ ] Basic metabolic panel and CBC
[ ] Management of [Specific Medication, e.g., blood thinners]

I will provide a detailed operative report following the procedure and will keep you updated on their postoperative progress. Please feel free to contact my office at [Phone Number] if you have any questions or concerns regarding this treatment plan.

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

Sincerely,

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