

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

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

**Medical Record Number:** [Insert MRN]

**Referring Physician:** [Insert Doctor Name]

**Reason for Referral:** [Insert Reason, e.g., Post-Traumatic Deformity, Congenital Anomaly, Post-Oncologic Resection]

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## 1. Chief Complaint and History of Present Illness

[Describe the patient's primary concern, the origin of the facial defect/deformity, and any previous surgeries or treatments.]

## 2. Clinical Assessment

**Physical Examination:** [Detail findings regarding facial symmetry, bone structure, soft tissue integrity, skin quality, and nerve function.]

**Functional Impairments:** [List issues such as difficulty breathing, vision obstruction, or mastication problems.]

## 3. Diagnostic Results

[Summarize findings from CT scans, MRIs, or photographic analysis.]

## 4. Impression and Diagnosis

[State the clinical diagnosis and the complexity of the reconstruction required.]

## 5. Proposed Surgical Plan

**Procedure(s):** [List specific procedures, e.g., Osteotomy, Skin Grafting, Microvascular Free Flap, Scar Revision.]

**Expected Outcomes:** [Outline the goals for functional restoration and aesthetic improvement.]

## 6. Risk and Informed Consent

[Document that risks including infection, scarring, nerve damage, and graft failure were discussed.]

## 7. Follow-up and Coordination of Care

[Outline the next steps, including pre-operative clearance or multidisciplinary consultations.]

Sincerely,

[Signature]

**[Physician Name, Title]**

[Department/Facility Name]