Date: [Insert Date]

To: [Requesting Physician Name]
Department: [Department Name]
Facility: [Facility Name]

RE: Second Opinion Radiology Consultation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

EXAMINATION TYPE: [e.g., MRI Brain, CT Abdomen, etc.]

DATE OF ORIGINAL SCAN: [Insert Date]

OUTSIDE ACCESSION NUMBER: [Insert Number]

CLINICAL HISTORY:

[Insert brief summary of patient symptoms and the reason for the second opinion request].

COMPARISON:

[List any prior studies used for comparison or state "None"].

FINDINGS:

[Provide detailed description of the imaging findings here].

IMPRESSION:

1. [Primary finding or diagnosis].
2. [Secondary findings or recommendations for follow-up].
3. [Note of agreement or disagreement with the original outside report, if applicable].

Consulting Radiologist: [Physician Name, MD/DO]
Sub-specialty: [e.g., Neuroradiology, Musculoskeletal]
Signature: _____