Date: [Date]

To: [Referring Physician Name]
Department: [Department/Clinic Name]
Address: [Street Address, City, State, Zip]

RE: Orthopedic Radiology Consultation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Date of Imaging: [Imaging Date]

Examination Type: [e.g., MRI Right Knee / CT Lumbar Spine / X-ray Left Shoulder]

Clinical Indication:
[Brief description of clinical symptoms and reason for referral]

Comparison:
[List prior relevant imaging studies or state "None"]

Findings:

Bones and Joints:
[Description of fractures, alignment, joint space narrowing, erosions, or osteophytes]

Soft Tissues:
[Description of ligaments, tendons, musculature, and presence of edema or effusions]

Other:
[Incidental findings or hardware evaluation]

Impression:
1. [Primary diagnosis/finding]
2. [Secondary findings]
3. [Recommendations for further imaging or clinical correlation]

Sincerely,

[Your Signature]

[Your Name, MD/DO]
[Title/Position]
[Contact Information]