Date: [Date]

Referring Physician: [Physician Name]
Facility: [Facility Name]
Address: [Address, City, State, Zip]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Patient ID: [ID Number]
Examination Date: [Date of Imaging]

RE: NEUROLOGICAL RADIOLOGY CONSULTATION

Exam Type: [e.g., MRI Brain with/without Contrast / CT Head]

Clinical History:
[Insert brief summary of patient symptoms and clinical indications for the scan].

Comparison:
[None / Specify date and type of previous imaging].

Technique:
[Describe imaging sequences and parameters used].

Findings:

- **Brain Parenchyma:** [Describe gray/white matter differentiation, signal abnormalities, or masses].
- **Ventricular System and CSF Spaces:** [Describe size, symmetry, and midline shift].
- **Vasculature:** [Describe major intracranial vessels and flow voids].
- **Extra-axial Spaces:** [Note any collections, hemorrhages, or meningeal enhancement].
- **Skull and Soft Tissues:** [Describe bone structures and visualised extracranial tissues].

Impression:

1. [Primary finding/Diagnosis]
2. [Secondary findings]
3. [Recommendations for follow-up or further clinical correlation]

Sincerely,

[Radiologist Signature]
[Radiologist Name, MD/DO]

[Subspecialty: Neuroradiology]
[Contact Information]