Date: [Date]

Referring Physician: [Physician Name]
Department: [Department Name]
Facility: [Facility Name]

RE: Pediatric Radiology Consultation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]
Exam Type: [e.g., Pediatric Chest X-ray, Abdominal Ultrasound]

Clinical Indication:
[Insert reason for exam and clinical history provided]

Comparison:
[Insert details of prior imaging studies or state "None"]

Technique:
[Describe the imaging protocol used, including any sedation or pediatric-specific dose reduction techniques]

Findings:
[Detailed description of findings including organ systems, presence/absence of pathology, and pediatric-specific developmental considerations]

Impression:
1. [Primary diagnosis or finding]
2. [Secondary findings]
3. [Recommendations for follow-up or further imaging]

Sincerely,

[Signature]
[Radiologist Name, MD/DO]
[Title/Board Certification]
[Contact Information]