Date: [Insert Date]

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

RE: Oncology Imaging Consultation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Exam Reviewed: [Type of Scan, e.g., CT Chest/Abdomen/Pelvis]
Date of Exam: [Date of Original Scan]

Clinical History

[Insert brief summary of diagnosis, current treatment cycle, and specific clinical question, e.g., evaluation of treatment response].

Comparison

[List prior imaging dates and modalities used for comparison].

Findings

Primary Tumor/Site: [Describe current dimensions, morphology, and changes compared to prior studies].

Lymph Nodes: [Describe regional and distant lymphadenopathy].

Metastatic Workup: [Describe findings in liver, lungs, bone, or other common metastatic sites].

Other Findings: [Incidental findings or treatment-related changes].

Impression

1. [Summary of overall oncologic status: e.g., Partial Response, Stable Disease, or Progression].
2. [Key measurement changes based on RECIST 1.1 or applicable criteria].
3. [Recommendations for further imaging or clinical correlation].

Thank you for the opportunity to participate in the care of this patient.

Sincerely,

[Radiologist Name, MD/DO]
[Title/Subspecialty, e.g., Neuroradiologist / Body Imaging]
[Contact Information]