Date: [Date]

To: [Referring Physician Name]
Clinic/Department: [Referring Clinic Name]
Address: [Referring Address]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]
Date of Exam: [Date of Imaging]

Subject: Outpatient Radiology Interpretation Consultation

Dear Dr. [Referring Physician Last Name],

At your request, I have performed a formal interpretation and consultation regarding the imaging studies for the patient listed above.

Examination Type: [e.g., MRI Lumbar Spine without Contrast]

Clinical Indication:
[Briefly state reason for exam, e.g., Chronic lower back pain with radiculopathy]

Comparison:
[Note any prior studies compared, or state "None"]

Findings:
[Detailed description of observations]

Impression:
1. [Primary Finding/Diagnosis]
2. [Secondary Finding]
3. [Incidental Finding]

Recommendations:
[Suggested follow-up imaging, clinical correlation, or specialist referral]

Thank you for the opportunity to participate in this patient's care. Please contact me at [Phone Number] if you wish to discuss these results further.

Sincerely,

[Your Signature]

[Your Name, MD/DO]
[Radiology Sub-specialty, if applicable]
[Facility/Practice Name]