Date: [Insert Date]

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

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

RE: Diagnostic Radiology Consultation / Second Opinion Interpretation

Examination Type: [e.g., MRI Brain, CT Abdomen, X-Ray Chest]
Date of Original Imaging: [Insert Date of Exam]
Accession Number: [Insert Number]

Clinical Indication:
[Briefly describe the reason for the scan or the specific clinical question to be addressed].

Comparison:
[List any prior studies used for comparison, or state "None"].

Technique:
[Describe the sequences, views, or protocols used in the provided images].

Findings:
[Provide a detailed description of the anatomical findings and any abnormalities noted].

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

Sincerely,

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