[Date]

To the Parent or Guardian of: [Patient Name]
[Patient Date of Birth]
[Address]
[City, State, Zip Code]

RE: MISSED DIAGNOSTIC IMAGING APPOINTMENT

Dear Parent or Guardian,

Our records indicate that [Patient Name] missed a scheduled diagnostic imaging appointment (such as an X-ray, Ultrasound, or MRI) on [Date of Appointment] at [Facility Name].

We are concerned because this imaging was ordered by [Ordering Physician Name] to help us properly diagnose or monitor your child's health condition. Failing to complete this test may delay necessary medical treatment or result in an incomplete care plan.

Please take the following steps as soon as possible:

- Call the imaging department at [Phone Number] to reschedule the appointment.
- If the imaging has already been completed at a different facility, please notify our office so we can request the results.
- If you no longer wish to proceed with this test, please contact us to discuss the risks of not completing the imaging.

If you have any questions or are experiencing difficulties scheduling this appointment, please call our office at [Office Phone Number]. Your child's health is our priority.

Sincerely,

[Physician/Provider Name]
[Practice Name]
[Office Contact Information]