**Date:** [Insert Date]

**To:** Radiology Department / Imaging Center
**Facility Name:** [Insert Facility Name]
**Address:** [Insert Address]

**RE: Post-Operative Radiology Request**

**Patient Information:**
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/MRN: [Insert ID Number]

**Clinical History:**
Procedure Performed: [Insert Type of Surgery]
Date of Surgery: [Insert Date of Surgery]
Clinical Indication: Post-operative follow-up to assess [e.g., hardware placement, healing progress, or complications].

**Imaging Requested:**
Type of Study: [e.g., X-ray, CT Scan, MRI, Ultrasound]
Anatomical Site: [e.g., Left Knee, Lumbar Spine]
Special Instructions: [e.g., Include hardware views, with/without contrast]

Please forward the formal report and digital images to my office upon completion.

Sincerely,

[Doctor Name]
[Credentials]
[Practice Name]
[Phone Number]
[Fax Number]