

Orthopedic Consultation Request

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

Address: [Insert Patient Address]

Referring Physician: [Insert Referring Physician Name]

Contact Information: [Insert Contact Information]

Subject: Request for Orthopedic Consultation - Knee Pain Assessment

Dear [Orthopedic Specialist's Name],

I am writing to refer my patient, [Insert Patient Name], for an orthopedic consultation regarding ongoing knee pain. The patient has been experiencing [briefly describe the symptoms, e.g., pain, swelling, difficulty in movement] for [duration]. Despite [mention any treatments tried, e.g., rest, physiotherapy], the condition has not improved.

Clinical History:

- Medical History: [Insert relevant medical history]
- Previous Treatments: [Insert treatments or interventions tried]
- Medication: [Insert any current medications]

Please perform a thorough assessment of the patient's condition and advise on the appropriate management and treatment options. I appreciate your expertise in this matter.

Thank you for your attention to this referral.

Sincerely,

[Referring Physician's Name]

[Referring Physician's Contact Information]