

**Date:** [Date]

**To:** [Pain Management Clinic Name/Physician Name]

**Address:** [Clinic Address]

**Fax/Phone:** [Clinic Contact Information]

**RE: Referral for Chronic Pain Management**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Insurance:** [Insurance Provider & ID Number]

Dear Dr. [Consultant Last Name],

I am writing to formally refer [Patient Name] for evaluation and multidisciplinary management of chronic pain.

**Primary Pain Diagnosis:** [e.g., Chronic Lower Back Pain, Fibromyalgia, Complex Regional Pain Syndrome]

**Clinical Summary:**

The patient has been experiencing persistent pain for [Duration]. The pain is described as [Description: e.g., sharp, burning, aching] and is located in [Body Area]. It significantly impacts their activities of daily living and quality of life.

**Current/Previous Treatments:**

The following interventions have been attempted:

- **Medications:** [e.g., NSAIDs, Gabapentinoids, Muscle Relaxants]
- **Physical Therapy:** [Duration and Results]
- **Interventions:** [e.g., Prior injections or imaging results]

**Goals of Referral:**

I am seeking your expertise for:

- Diagnostic clarification
- Interventional pain management procedures
- Optimization of non-opioid pharmacological therapy
- Development of a comprehensive long-term management plan

Relevant medical records, recent imaging reports, and current medication lists are attached to this referral.

Thank you for participating in the care of this patient. Please contact my office at [Your Phone Number] if you require further information.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Practice Name]

[NPI Number]