

Date: [Date]

To: [Pain Management Specialist Name]

Clinic Name: [Clinic/Hospital Name]

Address: [Clinic Address]

RE: Referral for Chronic Post-Surgical Pain Management

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Health Insurance/ID: [ID Number]

Dear Dr. [Specialist Last Name],

I am writing to formally refer [Patient Name] for specialized evaluation and management of chronic pain following a post-surgical complication. The patient underwent [Name of Surgery] on [Date of Surgery] performed by [Surgeon Name].

Clinical History:

The post-operative period was complicated by [Describe Complication, e.g., infection, nerve injury, hematoma]. Despite standard healing time, the patient continues to experience persistent pain described as [Description of Pain, e.g., burning, sharp, constant] localized to [Specific Area].

Current Symptoms:

The patient reports a pain intensity of [X/10] on the visual analog scale. This pain significantly impacts their [Sleep/Mobility/Activities of Daily Living]. Physical examination reveals [Mention findings, e.g., allodynia, restricted range of motion].

Previous Interventions:

To date, management has included:

- Medications: [List Medications, e.g., NSAIDs, Gabapentinoids]
- Physical Therapy: [Details/Duration]
- Other: [e.g., Injections, Imaging results]

Referral Objective:

I am requesting your expertise for a comprehensive pain assessment and a multidisciplinary treatment plan to improve the patient's functional status and quality of life.

Enclosed please find the operative reports, recent imaging, and current medication list. Please contact my office at [Phone Number] if you require further information.

Thank you for your assistance in the care of this patient.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Credentials]

[Practice Name]