Date: [Date]

To: [Pain Management Specialist Name]
Clinic Name: [Pain Management Clinic Name]
Address: [Clinic Address]

RE: Patient Referral for Chronic Pain Management
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Contact Number: [Patient Phone Number]

Dear Dr. [Recipient Last Name],

I am writing to formally refer [Patient Name] to your clinic for expert management of chronic pain associated with [Primary Orthopedic Diagnosis, e.g., Degenerative Disc Disease or Osteoarthritis].

Clinical History:
The patient has been under my care since [Date] for [Location of Pain, e.g., Lower Back/Right Hip]. Despite orthopedic interventions including [List Treatments, e.g., Physical Therapy, Corticosteroid Injections, or Surgical Consultation], the patient continues to experience significant pain that interferes with their daily activities and quality of life.

Current Symptoms:
[Briefly describe pain type, frequency, and severity]

Current Medications:
[List current pain medications and dosages]

Recent Imaging/Tests:
[Mention relevant X-rays, MRI, or CT scans and dates]

Referral Objective:
I am requesting your assistance in providing advanced pain modulation strategies, which may include [e.g., nerve blocks, radiofrequency ablation, or medication optimization], as the patient is not currently a candidate for further surgical intervention.

Enclosed please find the patient's recent clinical notes and imaging reports. Should you require any further information, please contact my office at [Your Phone Number].

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

Sincerely,

[Your Signature]
[Your Full Name, MD/DO]
[Orthopedic Practice Name]