Date: [Date]

To: [Pain Management Clinic Name]
Attn: [Physician Name, if known]
Address: [Clinic Address]

RE: Referral for Chronic Pain Management

Patient Name: [Patient Name]
Date of Birth: [DOB]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Employer: [Employer Name]
Insurance Carrier: [Insurance Company Name]

Dear Dr. [Physician Last Name],

I am referring the above-named patient to your clinic for a comprehensive evaluation and treatment of chronic pain resulting from a work-related injury. The patient sustained an injury to their [Specific Body Part] on [Date of Injury].

Despite previous treatments, including [List Previous Treatments, e.g., Physical Therapy, Medication, Surgery], the patient continues to experience persistent pain that significantly impacts their functional capacity and ability to return to work. My current diagnosis is [Diagnosis].

Requested Services:

- Initial consultation and pain assessment
- Development of a multidisciplinary pain management plan
- Medication management and review
- [Optional: Interventional procedures/Injections]
- [Optional: Psychological screening for chronic pain]

Please provide a detailed consultation report, including your clinical findings, proposed treatment plan, and any specific functional limitations or work restrictions. All bills and reports should be submitted to the insurance carrier listed above referencing the claim number provided.

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

Sincerely,

[Your Name/Signature]
[Your Title/Practice Name]
[Your Address]