Date: [Insert Date]

To: [Pain Management Specialist Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

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

Dear Dr. [Specialist Last Name],

I am writing to formally refer [Patient Name] for evaluation and management of chronic pain secondary to the following neurological disorder: [Insert Neurological Diagnosis, e.g., Multiple Sclerosis, Parkinson's Disease, Peripheral Neuropathy].

Clinical Background:
The patient was diagnosed with [Condition] in [Year]. They have been experiencing persistent pain for [Duration] months/years. The pain is described as [Description: e.g., burning, electric shocks, stabbing] and primarily affects [Location: e.g., lower extremities, back, neck].

Current Symptoms and Impact:
[Briefly describe how pain affects daily life, sleep, or mobility].

Previous Interventions:
The patient has previously attempted the following treatments with limited success:
- Medications: [List, e.g., Gabapentin, Pregabalin, NSAIDs]
- Therapies: [List, e.g., Physical Therapy, TENS]
- Procedures: [List, e.g., Nerve blocks]

Referral Goal:
I am seeking your expertise for a comprehensive pain assessment and recommendations for specialized interventions such as [mention specific requests, e.g., medication adjustment, spinal cord stimulation, or interventional blocks].

Attached are the patient's recent clinical notes, imaging results (MRI/CT), and current medication list.

Thank you for your assistance in the care of this patient. Please feel free to contact my office at [Phone Number] if you require further information.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Credentials]
[Clinic Name]