

**Date:** [Insert Date]

**To:** [Consultant Name/Intake Coordinator]

**Clinic Name:** [Rheumatology & Chronic Pain Management Clinic]

**Address:** [Clinic Address]

**RE: Referral for Patient Evaluation and Management**

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

**Date of Birth:** [DOB]

**Health Number:** [ID Number]

**Contact Information:** [Phone/Email]

Dear Dr. [Consultant Last Name],

I am writing to formally refer [Patient Name] for specialized evaluation and management of suspected autoimmune-related chronic pain. This patient presents with persistent symptoms that suggest a systemic inflammatory or connective tissue disorder.

**Clinical Presentation:**

- **Primary Symptoms:** [e.g., Symmetrical joint pain, morning stiffness > 1 hour, fatigue]
- **Duration:** [e.g., 6 months]
- **Functional Impact:** [e.g., Difficulty with activities of daily living, reduced mobility]

**Relevant Laboratory and Imaging Results:**

- **Serology:** [e.g., Elevated CRP/ESR, Positive ANA/RF/Anti-CCP]
- **Imaging:** [e.g., X-ray/Ultrasound findings of joint erosion or synovitis]
- **Other:** [e.g., HLA-B27 status]

**Current Medications & Past Interventions:**

- [List current medications, e.g., NSAIDs, Prednisone]
- [List failed treatments or physical therapy history]

**Reason for Referral:**

I am seeking your expertise for diagnostic clarification, disease activity assessment, and the development of a long-term multidisciplinary pain management strategy, including the initiation of DMARDs or Biologics if indicated.

Thank you for your assistance in the care of this patient. Please find the attached lab reports and clinical notes for your review.

Sincerely,

[Your Name/Signature]  
[Title/Medical License Number]  
[Facility Name]  
[Contact Phone Number]