Date: [Date]

To: Chronic Pain Management Clinic
Attn: Intake Coordinator / Pain Specialist

RE: Referral for Specialized Pain Management
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

Dear Pain Management Team,

I am referring this patient for consultation and ongoing management of chronic pain associated with their oncological diagnosis.

Primary Diagnosis: [Type and Stage of Cancer]
Current Treatment Status: [e.g., Active Chemotherapy, Palliative Care, Post-Surgical]

Pain Profile:

- **Nature of Pain:** [e.g., Neuropathic, Bone Pain, Visceral]
- **Location:** [Primary sites of pain]
- **Current Regimen:** [List current analgesics and dosages]
- **Pain Score:** [e.g., 7/10 despite current medication]

Reason for Referral:
[e.g., Escalating opioid requirements, localized nerve block evaluation, or intractable pain interfering with quality of life.]

Please find the patient's most recent clinical notes, imaging reports, and medication list attached. We look forward to your multidisciplinary input to optimize this patient's comfort.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Department of Oncology]
[Facility Name]
[Phone Number]
[Fax Number]