Date: [Date]

To: [Pain Management Clinic Name]
Attn: Referral Coordinator
Address: [Clinic Address]
Phone/Fax: [Clinic Phone/Fax]

RE: Patient Referral for Chronic Pain Management Evaluation
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance: [Insurance Provider/ID]

Dear Dr. [Provider Name],

I am referring the above-named patient to your clinic for a comprehensive chronic pain management evaluation and multidisciplinary intervention.

Primary Diagnosis: [e.g., Chronic Low Back Pain, Fibromyalgia, CRPS]

ICD-10 Code(s): [Insert Codes]

Clinical History:
The patient has been receiving physical therapy at our facility since [Start Date] for chronic pain lasting [Duration]. Despite compliance with therapeutic exercise, manual therapy, and [Other Modalities], the patient continues to experience significant functional limitations and high pain levels (averaging [#/10] on the VAS scale).

Current Functional Limitations:
[Briefly list, e.g., inability to sit for >20 mins, sleep disturbances, gait abnormalities]

Reason for Referral:
At this time, the patient's progress has plateaued. I am requesting your expertise for further diagnostic workup, medication management, or interventional procedures to help modulate their pain levels, which will allow for more effective participation in their rehabilitative program.

Included with this letter are the patient's initial physical therapy evaluation, most recent progress note, and current home exercise program.

Please contact my office at [Your Phone Number] if you require further information. We look forward to collaborating on this patient's care.

Sincerely,

[Your Name], PT, DPT
[Facility Name]

[Phone Number]
[Fax Number]