

Date: [Insert Date]

To: [Consultant Name/Intake Coordinator]

Clinic Name: [Sports Medicine/Chronic Pain Clinic Name]

Address: [Clinic Address]

RE: Referral for Chronic Pain Management and Sports Medicine Assessment

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Contact Number: [Phone Number]

Dear Doctor,

I am writing to formally refer this patient for specialized evaluation and management of chronic pain related to a sports-related injury.

Clinical History:

The patient sustained an injury to the [Body Part/Joint] on [Date of Injury]. Despite initial conservative treatment, they continue to experience persistent pain lasting [Number of Months/Years].

Current Symptoms:

[Describe nature of pain: dull, sharp, burning, etc.]

[Describe functional limitations or impact on physical activity]

Previous Interventions:

[List previous treatments: Physiotherapy, NSAIDs, Corticosteroid injections, etc.]

Diagnostic Results:

[List relevant X-ray, MRI, or CT scan findings]

Referral Goals:

I am requesting your expertise for:

- Comprehensive diagnostic review
- Advanced pain management strategies (interventional or pharmacological)
- A structured rehabilitation plan to return to sports/activity

Thank you for seeing this patient in consultation. Please contact my office if further information is required.

Sincerely,

[Your Signature]

[Your Name]

[Your Title/Designation]
[Practice Name/Contact Info]