

Date: [Date]

To: [Pain Management Specialist Name/Clinic Name]

Address: [Clinic Address]

Fax/Phone: [Clinic Contact Info]

RE: Patient Referral for Chronic Pain Management

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Injury: [Date of Accident]

Insurance/Claim Number: [Claim Number]

Dear Dr. [Provider Last Name],

I am referring [Patient Name] to your clinic for a comprehensive evaluation and management of chronic pain resulting from a motor vehicle accident that occurred on [Date of Accident].

Clinical History:

The patient sustained [Type of Injuries, e.g., cervical whiplash, lumbar strain, disc herniation] during the aforementioned accident. Despite conservative treatments including [List treatments, e.g., physical therapy, chiropractic care, NSAIDs, rest], the patient continues to experience persistent, debilitating pain that interferes with daily activities and sleep.

Current Symptoms:

The patient currently reports:

- Primary Pain Location: [e.g., Lower back, radiating to legs]
- Pain Character: [e.g., Sharp, aching, burning, constant]
- Associated Symptoms: [e.g., Numbness, weakness, limited range of motion]

Requested Services:

I am requesting a consultation to address the following:

- Specialized pain assessment and diagnostic workup.
- Interventional pain management options (e.g., injections, blocks).
- Medication review and optimization.
- Development of a long-term chronic pain multidisciplinary care plan.

Enclosed are the patient's recent imaging reports (MRI/X-ray) and relevant clinical progress notes for your review. Please contact my office if you require any further documentation.

Thank you for participating in the care of this patient.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[Phone Number]