Date: [Date]

To: [Pain Management Specialist Name]
Clinic Name: [Clinic Name]
Address: [Clinic Address]

RE: Referral for Chronic Pain Management Assessment
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient Phone: [Phone Number]

Dear Dr. [Specialist Last Name],

I am referring this patient for a comprehensive geriatric pain management assessment. The patient is a [Age]-year-old individual presenting with chronic pain that is significantly impacting their daily function, mobility, and quality of life.

Primary Pain Complaints:
[Describe location, duration, and nature of pain, e.g., lower back, osteoarthritis, neuropathy]

Current Functional Status:
[Describe impact on ADLs, mobility, sleep, and mental health]

Relevant Medical History:
[List comorbidities, e.g., Renal impairment, cognitive decline, cardiovascular history]

Current Medications:
[List medications and dosages, noting any failed trials of analgesics]

Assessment Goals:
1. Evaluation for non-pharmacological and pharmacological interventions.
2. Optimization of medication to minimize polypharmacy and side effects.
3. Improvement in functional independence and pain interference.

Attached are recent lab results, imaging reports, and a full list of current medications. Please contact my office if you require further information.

Sincerely,

[Your Name/Signature]
[Your Title/Role]
[Facility/Practice Name]
[Phone Number]
[Fax Number]