Date: [Date]

To: [Pain Management Clinic Name/Physician Name]
Fax/Address: [Clinic Contact Information]

From: [Referring Physician Name]
Department: Emergency Department
Facility: [Hospital Name]

RE: Patient Referral for Chronic Pain Management

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Health Card/ID Number: [ID Number]

Phone Number: [Patient Phone Number]

Reason for Referral:

The patient presented to the Emergency Department on [Date] with an exacerbation of chronic pain. Following an acute assessment and stabilization, it has been determined that the patient requires specialized outpatient management for long-term pain control and functional improvement.

Clinical Summary:

- **Primary Pain Site:** [Location, e.g., Lower Back, Neuropathic]
- **Duration:** [Months/Years]
- **Emergency Department Interventions:** [Tests performed, medications administered]
- **Relevant Medical History:** [Brief History]

Current Medications (Discharge):

[List medications, dosages, and frequency]

Referral Goals:

[E.g., Medication optimization, interventional procedures, multidisciplinary support, or weaning of opioids]

Urgency: [Routine / Urgent]

Please contact the patient directly to schedule an initial consultation. Relevant imaging and lab results are attached to this referral.

Sincerely,

[Physician Signature]
[Physician Name (Printed)]
[Provider License Number]
[Contact Phone/Pager]