

Date: [Insert Date]

To: [Orthopedic Surgeon Name]

Clinic Name: [Clinic/Hospital Name]

Address: [Clinic Address]

RE: Referral for Orthopedic Consultation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Insurance: [Insurance Provider/Policy Number]

Dear Dr. [Surgeon Last Name],

I am referring this patient to your care for an orthopedic evaluation of symptomatic **Degenerative Joint Disease (DJD)** involving the [Specific Joint, e.g., Left Knee/Right Hip].

Clinical Presentation:

The patient reports a [Number]-month/year history of progressive pain, stiffness, and [mention mechanical symptoms like clicking or locking]. The pain is currently rated as [X]/10 and is exacerbated by [weight-bearing/activity].

Previous Interventions:

To date, the patient has attempted the following conservative treatments:

- Physical Therapy: [Duration/Outcome]
- Medications: [NSAIDs/Analgesics used]
- Injections: [Corticosteroid/Hyaluronic acid, if applicable]
- Activity Modification: [Details]

Imaging Results:

[X-ray/MRI] performed on [Date] demonstrates [mention findings, e.g., joint space narrowing, osteophytes, or subchondral sclerosis].

Reason for Referral:

The patient's symptoms are no longer adequately managed by conservative measures. I am requesting your expertise to discuss surgical options, including potential [Total Joint Arthroplasty/Arthroscopy], or advanced pain management strategies.

Please find the enclosed relevant medical records and imaging reports. Thank you for your consultation and ongoing care of this patient.

Sincerely,

[Referring Physician Signature]

[Referring Physician Printed Name]

[Practice Name]
[Phone Number]