Date: [Date]

To: [Referring Physician Name]
Address: [Referring Physician Address]
Fax: [Referring Physician Fax Number]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Date of Consultation: [Date of Visit]

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] to our clinic for an interventional pain management consultation regarding the consideration of a Spinal Cord Stimulator (SCS) trial.

Clinical History:
The patient presents with chronic pain localized to the [Location, e.g., lower back and bilateral legs]. Diagnosis includes [Diagnosis, e.g., Failed Back Surgery Syndrome, Complex Regional Pain Syndrome]. The patient has failed conservative treatments including physical therapy, pharmacological management, and previous interventional injections.

Physical Examination Findings:
[Insert Brief Physical Exam Summary, e.g., limited ROM, sensory deficits, or normal motor strength].

Assessment and Plan:
Based on the patient's refractory symptoms and clinical presentation, I have recommended a Spinal Cord Stimulator (SCS) Trial. The patient understands that this is a temporary, minimally invasive procedure to evaluate the efficacy of neuromodulation in reducing their pain and improving functional status.

Plan of Action:

- **Psychological Clearance:** The patient has been referred for a mandatory pre-surgical psychological evaluation.
- **Imaging:** Recent MRI/CT of the [Spine Region] has been reviewed for safe lead placement.
- **Insurance Authorization:** We are currently initiating the prior authorization process for the procedure.
- **Procedure:** Upon clearance, the patient will be scheduled for a percutaneous SCS trial lasting [Number] days.

I will provide an update following the completion of the trial regarding the patient's response and any plans for permanent implantation.

Sincerely,

[Doctor Signature]
[Doctor Name, Credentials]
[Practice Name]
[Phone Number]