Date: [Date]

To: [Referring Physician Name]
Address: [Referring Clinic/Hospital Address]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Procedure: Peripheral Nerve Block

Dear Dr. [Referring Physician Last Name],

I had the pleasure of seeing [Patient Name] in consultation for the management of chronic/acute pain localized to the [Specific Body Region].

Clinical History:
The patient describes pain characterized as [Description of Pain, e.g., burning, sharp, radiating]. Previous treatments including [Medications/Physical Therapy/Prior Injections] have provided [Amount of Relief].

Physical Examination:
Findings are consistent with [Diagnosis, e.g., Neuropathy, Entrapment, Post-Surgical Pain] involving the [Specific Nerve].

Plan:
After discussing the risks, benefits, and alternatives, the patient has elected to proceed with an interventional **[Specific Type of Nerve Block, e.g., Ilioinguinal, Suprascapular, Femoral] Nerve Block**. This procedure will be performed under [Ultrasound/Fluoroscopic] guidance using a combination of local anesthetic and [Steroid/Adjuvant].

Goals of Intervention:
1. Diagnostic confirmation of the pain generator.
2. Therapeutic reduction in pain intensity.
3. Improvement in functional mobility.

A follow-up appointment will be scheduled [Number of Weeks] after the procedure to evaluate the efficacy of the block and determine the next steps in the care plan.

Thank you for this kind referral.

Sincerely,

[Doctor Signature]
[Doctor Printed Name]
[Practice Name]