Date: [Date]

Referring Physician: [Doctor Name]
Patient Name: [Patient Name]
Date of Birth: [DOB]
Procedure Date: [Date of Procedure]

Subject: Consultation for Major Intra-Articular Joint Injection

Dear [Referring Physician Name],

Thank you for referring [Patient Name] for an interventional evaluation regarding chronic pain in the [Left/Right] [Shoulder/Hip/Knee].

Clinical History:
The patient presents with persistent pain described as [Description of Pain]. Previous conservative management, including [PT/Medication], has provided limited relief. Physical examination reveals [Brief Findings, e.g., decreased range of motion].

Procedure Performed:
After discussing risks, benefits, and alternatives, the patient consented to a fluoroscopic/ultrasound-guided intra-articular injection. Under sterile conditions, the [Joint Name] was accessed. Position was confirmed via [Imaging Modality/Contrast]. A solution consisting of [Dosage/Type of Corticosteroid] and [Dosage/Type of Local Anesthetic] was injected.

Assessment and Results:
The patient tolerated the procedure well with no immediate complications. Post-procedure, the patient reported a [Percentage]% reduction in pain while in the recovery area. This positive response supports the diagnosis of intra-articular pathology.

Plan:
1. Patient to maintain a pain diary for the next 7 days.
2. Resume physical therapy in [Number] days.
3. Follow-up in this clinic in [Time Frame].

It is a pleasure to participate in the care of your patient. Please contact me if you have any questions.

Sincerely,

[Your Name, MD/DO]
[Your Practice Name]
[Contact Information]