Date: [Date]

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

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

Dear Dr. [Referring Physician Last Name],

Thank you for referring [Patient Name] for an interventional pain management consultation regarding chronic lower extremity pain. After a comprehensive evaluation, I have recommended a Lumbar Sympathetic Block.

Clinical Indication:
The patient presents with symptoms consistent with [Complex Regional Pain Syndrome / Peripheral Vascular Disease / Neuropathic Pain]. The block is indicated for both diagnostic purposes to determine the involvement of the sympathetic nervous system and for therapeutic relief of sympathetically maintained pain.

Procedure Plan:
The procedure will be performed under fluoroscopic or CT guidance. A needle will be advanced to the anterolateral aspect of the [L2/L3/L4] vertebral body to target the sympathetic chain. Following negative aspiration and a contrast spread check, a solution of local anesthetic (and potentially a steroid or neurolytic agent) will be injected.

Goals of Treatment:
1. To reduce pain intensity and improve distal limb perfusion.
2. To facilitate participation in physical therapy.
3. To confirm the diagnosis of sympathetically mediated pain.

Risks and Consent:
The patient has been informed of potential risks, including infection, bleeding, intravascular injection, nerve injury, and temporary sympathetic side effects such as warmth or swelling of the leg. Informed consent has been obtained.

We will provide you with a detailed procedure note and follow-up report regarding the patient's response to the block. Please feel free to contact my office if you have any questions.

Sincerely,

[Your Name, MD/DO]
[Your Practice Name]
[Your Phone Number]