[Date]
[Referring Physician Name]
[Practice Name]
[Address]
[City, State, Zip]

RE: Psychiatric Evaluation for Pain Management Implant
Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Evaluation: [Date]

Dear [Physician Name],

I am writing to provide the results of the psychiatric evaluation for [Patient Name], who is being considered for a [Spinal Cord Stimulator / Intrathecal Pump] trial and permanent implantation.

The evaluation included a clinical interview, a review of psychiatric history, and an assessment of current coping mechanisms. The primary focus was to identify any contraindications for the procedure, such as untreated substance use disorders, active psychosis, or severe cognitive impairment.

Clinical Findings:

- The patient demonstrates a clear understanding of the procedure, its risks, and realistic expectations for pain relief.
- Current psychological symptoms are [well-managed / stable].
- The patient possesses the cognitive capacity and social support necessary for postoperative compliance.

Recommendation:

Based on this evaluation, the patient is **cleared** from a psychiatric standpoint to proceed with the pain management implant. There are no psychological contraindications identified at this time.

If you require further information, please contact my office at [Phone Number].

Sincerely,

[Signature]
[Provider Name, Credentials]
[License Number]
[Clinic Name]