Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Referring Physician: [Physician Name]
Discharge Date: [Date]

RE: DISCHARGE FROM ARTHRITIS PAIN MANAGEMENT PROGRAM

Dear [Patient Name/Doctor Name],

This letter serves to formally notify you that [Patient Name] has been discharged from the Arthritis Pain Management Clinic effective [Date].

Reason for Discharge:
[Goal achievement / Transfer of care / Patient request / Non-compliance]

Diagnosis:
[Type of Arthritis - e.g., Osteoarthritis / Rheumatoid Arthritis]

Summary of Treatment Received:
[Brief description of injections, physical therapy, or medications used during the program]

Current Medication Plan:
[List medications and dosages]

Ongoing Maintenance Recommendations:

- [Recommendation 1]
- [Recommendation 2]
- [Recommendation 3]

Follow-Up Care:
The patient has been advised to follow up with [Primary Care Provider/Specialist Name] in [Timeframe]. Should symptoms worsen or new symptoms occur, please seek immediate medical evaluation.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Clinic Name]