Date: [Date]

RE: Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]

To: [Receiving Provider Name/Facility Name]
Address: [Provider Address]

Dear [Provider Name],

I am writing to transition the care of [Patient Name] to your practice for the ongoing management of chronic pain. This patient has been under my care since [Start Date] for the following diagnoses:

- [Primary Diagnosis/ICD-10]
- [Secondary Diagnosis/ICD-10]

Current Treatment Plan:

The patient is currently prescribed the following medications:

- [Medication Name, Dosage, Frequency]
- [Medication Name, Dosage, Frequency]

Clinical History and Modalities:

In addition to pharmacological management, the patient has utilized [Physical Therapy/Injections/Behavioral Health/Interventional Procedures]. The current morphine milligram equivalent (MME) is [Total MME].

Compliance and Monitoring:

The patient is currently in compliance with their pain management agreement. The most recent Prescription Monitoring Program (PMP) check was performed on [Date]. The last Urine Drug Screen (UDS) was performed on [Date] with [Consistent/Inconsistent] results.

Reason for Transition:

[Reason: e.g., Patient relocation, Change in insurance, Specialist referral].

I have attached the patient's most recent clinical notes, diagnostic imaging reports, and the current pain management contract. My last date of service for this patient will be [Date]. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Signature]
[Provider Printed Name]
[NPI Number]
[Practice Name]