[Current Date]

[Receiving Physician Name]
[Receiving Clinic Name]
[Clinic Address]
[City, State, Zip Code]

RE: Transfer of Care for [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance Provider: [Insurance Name/ID]

Dear Dr. [Receiving Physician Last Name],

I am writing to formally transfer the pain management care of the above-mentioned patient to your clinic, effective [Date]. The patient is transitioning care due to [Reason: relocation, insurance change, specialist requirement].

Current Diagnoses:
- [Diagnosis 1, e.g., Chronic Lower Back Pain]
- [Diagnosis 2, e.g., Degenerative Disc Disease]
- [Diagnosis 3]

Current Medication Regimen:
- [Medication Name, Dosage, and Frequency]
- [Medication Name, Dosage, and Frequency]

Past Interventions and Treatments:
[List relevant treatments such as: Epidural steroid injections, Physical Therapy, Nerve blocks, etc.]

Clinical Summary:
[Brief summary of patient progress, compliance with pain contracts, and most recent UDS results].

Enclosed with this letter are the patient's medical records from the last [Number] months, including recent imaging (MRI/CT), laboratory results, and our current Pain Management Agreement.

I have provided the patient with a final [Number]-day bridge prescription to ensure continuity of care until their scheduled appointment with you on [Appointment Date].

Please contact my office at [Phone Number] if you require any additional information.

Sincerely,

[Signature]
[Referring Physician Name]
[Clinic Name]
[NPI Number]