

Date: [Date]

To: [Receiving Physician/Clinic Name]

Address: [Clinic Address]

Fax/Phone: [Contact Information]

RE: Patient Transfer of Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Date of Surgery: [Surgery Date]

Procedure: [Type of Surgery]

Dear Dr. [Recipient Last Name],

I am referring the above-named patient to your clinic for the ongoing management of post-surgical pain. The patient underwent [Procedure Name] performed by [Surgeon Name] at [Hospital Name].

Clinical Summary:

The patient's post-operative recovery has been complicated by [Type of Pain, e.g., chronic neuropathic pain, localized incision pain]. Current pain levels are reported as [Pain Scale 1-10] despite standard recovery protocols.

Current Medications:

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

Interventions to Date:

[List any nerve blocks, physical therapy, or specialty consultations already completed].

Reason for Transfer:

[Reason, e.g., transition from acute to chronic pain management, specialized interventional needs, or long-term opioid titration].

Enclosed are the patient's operative reports, recent progress notes, and current medication list. We have advised the patient that you will now be the primary provider managing their pain regimen.

Please contact our office at [Your Phone Number] if you require further information.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Title/Department]