

Date: [Date]

To: [Receiving Physician Name]

Department: [Department Name]

Facility: [Facility Name]

RE: Transfer of Care

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Diagnosis: Complex Regional Pain Syndrome (CRPS) Type [I/II]

Dear Dr. [Last Name],

I am writing to formally transfer the care of [Patient Name] to your clinic for the ongoing management of Complex Regional Pain Syndrome. The patient has been under my care since [Start Date].

Clinical History:

[Brief description of inciting injury, date of onset, and affected limb/region].

Current Symptoms:

[Description of current pain levels, vasomotor changes, swelling, and range of motion limitations].

Current Treatment Plan:

- **Medications:** [List current medications and dosages]
- **Interventions:** [List past nerve blocks, infusions, or SCS settings]
- **Therapies:** [List physical/occupational therapy status]

Reason for Transfer:

[Relocation / Requirement for specialized multidisciplinary care / Insurance change].

Pending Actions/Recommendations:

[List any upcoming procedures or needed medication titrations].

Attached are the last [Number] months of clinical notes, imaging reports, and diagnostic test results. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]