

[Physician Name]  
[Clinic/Facility Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]

Date: [Date]

To: [Referring Provider Name]  
[Referring Clinic Name]

RE: Pain Management Follow-Up Assessment  
Patient Name: [Patient Name]  
Date of Birth: [DOB]  
Date of Service: [Date of Visit]

Dear Dr. [Provider Last Name],

I saw [Patient Name] today for a follow-up evaluation regarding their chronic pain management. Below is a summary of our assessment and the updated treatment plan.

**Current Pain Status:**

The patient reports a current pain level of [Number]/10. Since the last visit, the patient reports that their pain has [improved/worsened/remained stable]. Functional status is currently [Description of mobility/daily activities].

**Medication Review:**

The patient is currently prescribed the following medications:

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

**Assessment:**

1. [Diagnosis/Condition 1]
2. [Diagnosis/Condition 2]

**Treatment Plan:**

- **Medication Changes:** [Details of changes or "Continue current regimen"]
- **Procedures:** [Scheduled injections or interventions, if any]
- **Therapy:** [Referrals to Physical Therapy, Behavioral Health, etc.]
- **Monitoring:** [Urine drug screen results, PDMP check, or pill counts]

**Follow-Up:**

The patient is scheduled to return to our clinic in [Number] weeks/months for further evaluation.

Thank you for the opportunity to participate in this patient's care. Please contact my office if you have any questions.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Credentials]