Emergency Chronic Pain Evaluation

Date: [Insert Date]

Patient Name: [Insert Patient's Name]

Patient ID: [Insert Patient ID]

Referring Physician: [Insert Physician's Name]

Referral Date: [Insert Referral Date]

Reason for Referral

The patient presents with exacerbated chronic pain conditions requiring urgent evaluation and management.

Medical History

Relevant history includes:

- Chronic pain diagnosis: [Specify Condition]
- Previous treatments: [List Treatments]
- Current medications: [List Medications]

Symptoms

The patient reports the following symptoms:

- [Symptom 1]
- [Symptom 2]
- [Symptom 3]

Assessment

Initial assessment is required for:

- Pain level on a scale of 1-10: [Insert Score]
- Impact on daily activities: [Insert Details]
- Physical examination findings: [Insert Findings]

Plan

Recommended immediate interventions include:

- [Intervention 1]
- [Intervention 2]
- [Intervention 3]

Follow-up

A follow-up appointment is recommended in [Insert Time Frame] to reassess the pain management plan.

Signature

_____
[Physician's Name], [Credentials]
[Practice Name]
[Contact Information]