

Chronic Pain Management Referral

Date: [Insert Date]

To: [Provider's Name]

Practice Name: [Practice/Clinic Name]

Address: [Provider's Address]

City, State, Zip: [City, State, Zip]

Dear [Provider's Name],

I am writing to refer my patient, [Patient's Name], for chronic pain management evaluation and treatment. [He/She/They] has been experiencing chronic pain due to [briefly describe condition(s) contributing to chronic pain, e.g., arthritis, fibromyalgia, etc.]. This pain has persisted for [duration of pain] and has significantly impacted [his/her/their] quality of life.

Current management strategies have included [list any current treatments, medications, or therapies], but [Patient's Name] continues to experience [describe symptoms or impact of pain on daily activities].

I believe that [he/she/they] would benefit from your expertise in chronic pain management, including possible options such as [mention any specific therapies or interventions you recommend].

Enclosed are [any relevant medical records, imaging, or notes that would assist the provider]. Please feel free to contact me at [Your Phone Number] or [Your Email] if you need further information.

Thank you for your attention to this matter.

Sincerely,

[Your Name] [Your Title/Position]

[Your Practice/Clinic Name]

[Your Address]

[Your City, State, Zip]

[Your Phone Number]

[Your Email]