# TESTIMONIAL LETTER CONCERNING THE PAIN TREATMENT OF _____

I am writing to describe my impressions of the pain management in this patient whom I have had contact with ___ times over the last _____ .

1. Relationship to patient: _____.
2. Length of time known: _____.
3. Condition prior to treatment:
   Work: _____.
   Sleep: _____.
   Relationships: _____.
   Mood: _____.
   Mobility: _____.
4. Improvements noted with treatment:
   Work: _____.
   Sleep: _____.
   Relationships: _____.
   Mood: _____.
   Mobility: _____.
5. Comments:
   _____
   _____
   _____
   _____
   _____.

I agree to notify Dr. _____ if I become aware of any problems developing from patient's treatment, such as abuse of medications or other substances, or if I change my mind, or have any reservations about the benefits of this treatment. I also agree to notify the doctor if I become aware of any improper or illegal activity involving this patient's treatment, such as giving, lending, or selling of medications, or if I become aware of any such activity involving Dr. _____ practice or any of his patients.

_____ _____

(Date) (Signature)