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Community Pain Management Program
Primary Care and Health Care Provider - Referral

Referral Form: This form is for the Fraser North (Tri-cities) Site only **Date:**_____

*** Please complete all information below**

Patient Information:

Name:_____ DOB:_____ PHN:_____

(dd/mm/yyyy)

Daytime Phone:_____ Cell phone:_____ Email:_____

Address:_____ (educational material only)

_____ (include postal code)

Referring Health Care Provider

☐ GP ☐ Nurse Practitioner ☐ Specialist ☐ Other

Name:_____ MSP #_____ Phone:_____

FAX:_____

Primary Care Provider ☐ as above **OR**

Name:_____ MSP #_____ Phone:_____ FAX:_____

Pain Clinic Criteria for Service

☐ The patient is aware:

- This is an Interdisciplinary Pain Program for patients interested in self-management skills
- The patient consents to the Pain Clinic contacting their Primary Care provider (PCP) & other Health Care Providers as needed to support care
- For patients who may have untreated addictions: Patient consents to MHSU program connection/referral prior or during Pain Clinic program if needed
- Patient lives within the catchment area of Fraser Health

1. Is this patient able to participate in light-moderate exercise program? ☐ Yes ☐ No
2. Active 3rd Party Patient? ☐ Yes ☐ No
   ☐ WCB ☐ ICBC ☐ Other_ Claim #_

- The Community Pain Management Program is an Interdisciplinary Clinic with a 8 week group/educational/self-management program
- Team includes PT,OT, Nurses & access to Pain Specialist, Pharmacist & MHSU services
- Patients will be triaged according to predetermined criteria and seen by the appropriate provider(s) in addition to group and self-management sessions.

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Duration of Pain ☐ 3-12 months ☐ 1-3 years ☐ Greater than 3 years

Location, condition or type of Pain(s)

Medical History ☐ Attached
☐ Brief relevant summary below

Substance Use History
☐ Attached ☐ Brief relevant history below
☐ Currently within MHSU program ☐ Opioid Antagonist Therapy (OAT) ☐ Other_____
☐ Addiction Medicine management Specialist Name:_____
Phone:_____
☐ Primary Care Provider management
☐ Other: _____
Goals of current management: _____

Mental Health
☐ None identified ☐ Attached
☐ Anxiety ☐ Depression ☐ Post –Traumatic Stress Syndrome
☐ other Psychiatric Disorder _____
☐ Followed by Mental Health Team Name:_____
Phone:_____
☐ Brief relevant summary below

Previous Pain Care/Treatment
☐ Unknown
☐ Brief summary below include any medications trials, Health Care Providers seen, treatment and interventional procedures

Include the following:

- Brief Pain Inventory (BPI) – please complete the attached form or provide a recent office copy from the past two months
- Medical History (include current medications & allergies)

☐ Pertinent scans and Imaging ☐ Pertinent consults from other physicians

- **FAX to : 604-582-4591: attention Clinical Coordinator Community Pain Clinics**