fraserhealth

Chronic Pain Clinic Referral Form
JPOCSC

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Form ID: Rev: April 2015

Patient Name: _____ ☐ New Patient ☐ Re-Referral

Surname Given Name Middle Date of Referral: _____

Address:_____

Date of Birth:_____ (DD/MM/YYYY) **PHN (Personal Health Number):** _____

Daytime Phone: _____**Cell Phone:** _____ **E-mail Address**: _____

Primary care provider (if different from referring source)

Name: _____

MSP#: _____

Phone: _____

Fax: _____

Referring Health care provider (if different from referring source)

Name: _____

☐ GP ☐ NP ☐ Specialist ☐ Hospitalist ☐ ER

☐ Other _____MSP#:_____

Phone: _____Fax: _____

Signature_____

Worksafe BC claim	Y / N	Case #
ICBC	Y / N	Claim #
Legal Claim	Y / N	

Language Services

☐ Interpreter Needed: _____

(Language)

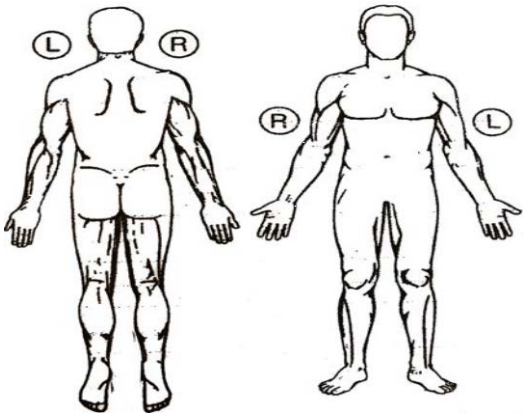
INCLUSION CRITERIA --- ALL MUST APPLY	EXCLUSION CRITERIA
☐ Patient has a primary care provider	☐ Untreated addiction
☐ All appropriate investigations have been done	☐ Ongoing infection source without treatment
☐Unresponsive to conventional treatment	☐ Medically unstable or suffers from a condition requiring inpatient care and monitoring
☐ Primary care provider(s) agree to participate with suggested regime	**** The clinic does not assume opioid prescribing ****
☐ Patient and/or caregivers are cognitively capable and willing to participate with suggested regime of therapy	**** There are NO addiction services in our clinic ****
☐ Patient aware and agreeable to the Pain Program including self-management strategies and interdisciplinary team members as an option	☐ Scheduled for surgery for pain issues ☐ Poorly controlled Psychopathology

The consultative service provided by the Pain Management Clinic is not for long term follow-up.
Patients must be followed by their family physicians during and after their participation in the program.
The Chronic Pain Clinic is an Interdisciplinary Clinic and patients will be triaged according to our predetermined criteria and seen by the appropriate provider(s).
The program is offered to patients living within the catchment area of Fraser Health Authority with some rare exceptions for those living outside this area.

☑	Referral Completion Check List	
☐	**Specialist reports relevant to pain issue**	
☐	**ALL Relevant Diagnostic Reports:**	
	Spinal Pain:	☐ Spine X-Ray (within 2 yrs.)
	Radicular Pain:	☐ Recent CT or MRI of area (within 2 yrs.)
	Patients over 60 yr History of malignancy	☐ Recent CT or MRI of area (within 2 yrs.)
	Chronic Headaches:	☐ Recent XR / CT / MR of head/neck (within 2 yrs.) ☐ Neurologist consultation (within 2yrs)
☐	List of current medications (** include anticoagulants)	

****Please include any additional consultation and investigations relevant to condition/situation****

Area of Pain



Reason for Referral (check all that are applicable)

☐ Self-management/programs

☐ Interdisciplinary team

☐ Request for specific Intervention_____

Duration of pain (**IMPORTANT)**

☐3-12 months ☐1-3 years ☐Greater than 3 years

Location and Description:

_____

_____

Medical History: ☐ No issues ☐ History attached

Allergies / Sensitivities: ☐ No issues ☐ List: _____

Mental Health: ☐ No issues ☐ Attached ☐ Anxiety disorder ☐ Mood Disorder ☐ Personality Disorder ☐ Psychotic Disorder ☐ PTSD

Followed by Mental Health Team: ☐ No ☐ Yes Name:_____ _____

Substance Use Concerns: ☐ Not applicable ☐ Active History ☐ Past History ☐ See Attached

Previous Pain Care: ☐ Occupational Therapy ☐ Physiotherapy ☐ Chiropractics ☐ Naturopath ☐ Massage Therapy ☐ Acupuncture ☐ Other:_____ _____

Medications Trialed: _____

Previous Procedure: ☐ Epidural Steroid ☐ Nerve Block ☐ Trigger Injection ☐ Radio Frequency ☐Other_____

Attended a Pain Self-Management Program: ☐ No ☐ Yes Name: _____ Date:_____

Activities of daily living: ☐ No issues ☐ Coping adequately ☐ Struggling to cope

Self-care: ☐ No issues ☐ Coping adequately ☐ Struggling to cope

Home activity: (e.g. cooking, cleaning) ☐ No issues ☐ Coping Adequately ☐ Struggling to cope ☐ Homemaker support

☐ Not working due to other reason please specify_____

Living situation:

☐ Alone ☐ With partner ☐ With family ☐ Care Facility ☐ Supportive Housing ☐ Subsidized Housing ☐ Shelter Other: _____

Mobility aid: ☐ None ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Scooter

Work history: ☐ Currently Working → Occupation: _____

☐ Student ☐ Retired ☐ Return to work program ☐ Not working due to pain