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OPIOID USE DISORDER & CHRONIC PAIN PROGRAM REFERRAL
Mental Health and Substance Use

Referral Form: Please choose one Community Pain Clinic site

☐ Fraser North (Tri-cities) ☐ Fraser South (Surrey) ☐ Fraser East (Chilliwack)

Date: **Please complete all known information below**

Referred From: ☐ **Substance Use Program Site** _____ OR **From:** ☐ _____

Referring Person:

Name: _____ Position: _____

Phone: _____ FAX: _____

Client Information:

Name: _____ DOB: _____ (dd/mm/yyyy)

PHN: _____

Daytime Phone: _____ Cell phone: _____

Email: _____

Address: _____ (educational material only)

_____ (include postal code)

Client's Primary Care Provider (PCP):

PCP name: _____ Phone: _____

FAX: _____

MSP # _____

Pain Clinic Criteria for Service

☐ The client is aware:

- This is an Interdisciplinary Pain Program for clients with Opioid Use Disorder (OUD), history of OUD or at risk for OUD.

Referrals for clients with other Substance Use Disorders will also be considered if space permits

- The client consents to the Pain Clinic contacting their Primary Care provider (PCP) & other Health Care Providers as needed to support care
- Client lives within the catchment area of Fraser Health

- 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, Social Work, 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 ☐ See summary below
☐ Currently within MHSU program ☐ Opioid Antagonist Therapy (OAT) ☐ Other_____
☐ Addiction Medicine management Specialist Name:_____
Phone:_____
☐ Other _____
Goals of current management:_____
Brief relevant summary

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 (PCXX104596) 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**