



fraserhealth

JPOCSC Pain Management Clinic Referral Form

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Form ID:

Rev: June 2018

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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: _____

<p>Referring health care provider</p> <p>Name: _____</p> <p>MSP#: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>	<p>Primary care provider (if different from referring source)</p> <p>Name: _____</p> <p><input type="checkbox"/> GP <input type="checkbox"/> NP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospitalist <input type="checkbox"/> ER</p> <p><input type="checkbox"/> Other _____ MSP#: _____</p> <p>Phone: _____ Fax: _____</p> <p>Signature _____</p>
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Worksafe BC claim	Y / N	Case #	<p>Language Services</p> <p><input type="checkbox"/> Interpreter Needed: _____</p> <p style="text-align: center;">(Language)</p>
ICBC	Y / N	Claim #	
Legal Claim	Y / N		

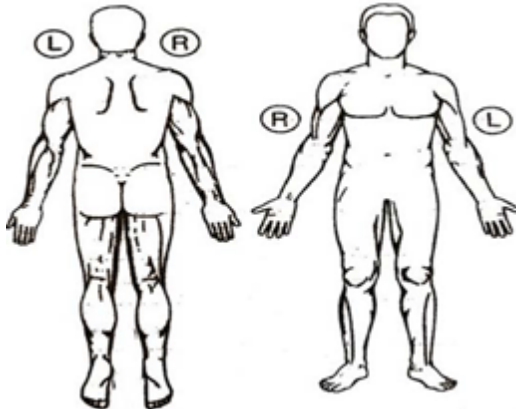
INCLUSION CRITERIA --- ALL MUST APPLY	EXCLUSION CRITERIA
<input type="checkbox"/> Patient has a primary care provider	<input type="checkbox"/> Untreated addiction
<input type="checkbox"/> All appropriate investigations have been done	<input type="checkbox"/> Ongoing infection source without treatment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

The Pain Management Clinic consultative services are not intended for long term follow-up. Patients are required to be monitored by family physicians during and after their participation in the program. The clinic is interdisciplinary and patients will be triaged according to predetermined criteria and seen by the appropriate provider(s).

The program is offered to patients living within the catchment area of the Fraser Health Authority with some rare exceptions for those living outside this area.

Pain Condition: _____

Duration of pain (IMPORTANT): 3-12 month's 1-3 yrs. Greater than 3 years



Please indicate specific location of pain on diagram provided

Please check the most relevant service required for your patient (choose ONE only):

<input type="checkbox"/> Procedural Only	<input type="checkbox"/> Self-Management	<input type="checkbox"/> Interdisciplinary Team
Diagnostic procedure care returned to PCP	Group classes and education resources	Complex patients requiring Bio-Psychosocial approach to pain management
<input type="checkbox"/> ESI <input type="checkbox"/> Facet blocks and rhizotomy <input type="checkbox"/> SNRB <input type="checkbox"/> TFESI <input type="checkbox"/> Sympathetic Block <input type="checkbox"/> Stellate <input type="checkbox"/> Lumbar	Not required to be seen individually by clinic team	May require 1:1 sessions with team members, including physiotherapy, occupational therapy, social work, pharmacy, nursing, psychology.
Other please specify		

REFERRAL COMPLETION CHECKLIST (Required):

N/A	YES	Please Attach
		All relevant diagnostic reports (XR/CT/MRI/US)
		All relevant consultation reports
		List of current medications (including anticoagulants, may need to be held if procedure indicated)
		List all allergies
		Medical/Surgical history
		Mental health history
		Substance use history
		Previous pain treatments (OT, PT, massage, acupuncture)
		Previous medications used for pain management
		Brief pain inventory
		Pain catastrophizing scale
		Intake form

