St JOSEPH's HEALTH CARE LONDON

Telephone: 519 646-6019
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Pain Management Website

PAIN MANAGEMENT PROGRAM REFERRAL

PLEASE NOTE THAT ALL REFERRALS MUST BE COMPLETED ON THIS FORM

Our program utilizes an interprofessional treatment service emphasizing building and supporting self-management. Pain clinic patients are actively involved in their treatment planning. Our goal is to assist in identifying and addressing treatment challenges and to also coordinate to access to available community treatment resources. Although we accept referrals from specialists and family physicians/NPs who are not the primary care provider, we believe it is important to include the patient's primary care provider in the referral process. Please complete the referral and send to the primary care provider to sign off to ensure they are aware of the referral and can add any additional relevant information prior to submitting.

Inclusion Criteria	Exclusion Criteria
• Patient has a primary care provider • Physician Agreement signed • Patient agrees to attend a Pain Management 101 session • Relevant scans (MRI, X-Ray, CT, etc.)	• Orofacial pain • Headache • Cancer pain • Primary Fibromyalgia: Canadian FMS Treatment Guidelines • Consults for IV Infusion Therapy

Patient Demographics and Physician Information

Please affix a label here (or complete information below)

Patient Name: _____

Health Card #: _____

Date of Birth: _____

Address: _____

Telephone Number: _____

Cell Phone: _____

Is a language interpreter required? ☐ YES ☐ NO

Language: _____

Referring Health Provider (if different than primary care provider, please forward referral to the GP/NP, as above)

Name: _____

Signature:

_____

Address: _____

_____

Phone: _____ Fax: _____

Primary Healthcare Provider: _____

Phone: _____ Fax: _____

Reason for Referral

☐ Interprofessional pain management (medical doctor, nursing, occupational, physiotherapy, pharmacist, psychologist, social work)

☐ Request for interventional pain management;
Specify:

_____

☐ Urgent: Complex Regional Pain Syndrome < 6 months
☐ Urgent: Postherpetic neuralgia < 6 months
☐ Transition from pediatric to adult chronic pain program
☐ WSIB specialty clinic
☐ WSIB claim # _____

Previous Pain-related Assessments/Treatments

☐ Has your patient been assessed by one of the Pain Management Program physicians in the past? ☐ YES ☐ NO
If yes, Dr. _____

☐ Have there been other pain clinics or specialists consulted for this pain program? ☐ YES ☐ NO
If yes, which clinics:

_____

☐ Physiotherapy
☐ Occupational Therapy
☐ Psychologist
☐ Community chronic pain management group

* Mandatory Fields

***Primary clinical question to be addressed for this consultation, including location, type and suspected cause of pain:**

***List of current medications, trialed medications, and previous treatments trialed:**

***Relevant images attached:** ☐ **YES** ☐ **Not Applicable**

Mental Health Concerns / Treatments

- ☐ None
- ☐ Depression
- ☐ Anxiety: GAD/PTSD/Panic / Pain-related
- ☐ Other: _____
- ☐ Symptoms poorly controlled *
- ☐ Symptoms are severe, will impede treatment*
- ☐ Pharmacotherapy
- ☐ Hospital-based mental health services
- ☐ Community-based mental health services
- ☐ FHT Social worker
- ☐ Community counselling agency
- ☐ Employee Assistance Program / Private Therapist
- ☐ Referral to CMHA, Mind Beacon, Bounce Back

*Mental health concerns can impede pain management. Please consider reviewing medications and arranging referral to one of the services above in advance of pain consultation, if required.

Comorbid Conditions / Potential Treatment Barriers

- ☐ Active substance abuse disorder
- ☐ Past substance use disorder
- ☐ Brain injury
- ☐ Cognitive impairment (Learning disability, developmental delay)
- ☐ Housing instability
- ☐ Poverty
- ☐ No medication coverage
- ☐ Travel distance / cost
- ☐ Visual/Hearing/Speech impairment
- ☐ Family planning/Pregnancy
- ☐ Treatment noncompliance
- ☐ Pending Litigation

Physician Agreement
(Must be completed for the referral to be processed)

One of our admission criteria is that Family Physicians play an active role in the treatment of their patients. We provide assessment and a treatment plan for your patient's chronic pain problem and, in some cases, will initiate and monitor treatment. Once the patient has been medically maximized and completed programming, we will return the patient to your ongoing care – including potentially prescribing opioids and/or oral cannabinoids. Once discharged, we can provide additional support by phone if needed.

By signing the referral form below, you acknowledge willingness to provide ongoing care to your patient including prescribing opioids or cannabinoids, if indicated, once they have been stabilized on these.

_____ _____

Family Physician Date