Providence Health Care

SPH Pain Clinic
St. Paul's Hospital
1081 Burrard Street
Vancouver, BC V6Z 1Y6

Phone: 604-806-8824
Fax: 604-806-9117
Website: www.providencehealthcare.org/pain-outpatient-clinics

SPH Pain Clinic Description:

- The interdisciplinary SPH Pain Clinic is for patients requiring treatment for pain that has been unresponsive to conventional treatment (e.g. physiotherapy, NSAIDs).
- Emphasis is placed on self-management and rehabilitation. All patients will participate in self-management classes if deemed suitable.
- Patients may be recommended for interventional pain treatment.
- The consultative service provided by the Pain Clinic is not for long-term follow-up. The Program typically follows patients for 6 to 12 months. Patients must be followed by their Primary Care Provider during and after their participation in the program. The Pain Clinic is an interdisciplinary program, and patients will be triaged according to our predetermined criteria and seen by the appropriate provider(s).
- The program does NOT assume prescribing, including opioids or other pain medications; the program may provide physician to physician consultation on dosing. The program can provide guidance for reducing opioid prescriptions.

Inclusion Criteria:

- Patient is 18 years of age or older
- Patient lives in Vancouver Coastal Health (VCH) catchment. Exception: If the service is not offered in your health authority, we may accept the referral
- The pain has been unresponsive to conventional treatment
- Patient is agreeable to learning self-management strategies and working with a multidisciplinary team
- Patient is agreeable to participate in a light-moderate activity or exercise program

Exclusion Criteria:

- Patient has an active untreated psychiatric condition (e.g. psychosis, severe depression, suicidality)
- Patient has active untreated substance use disorder
- Referral source's primary goal is medical legal consultation, or to obtain controlled substances, including opioid prescriptions
- Patient has an ongoing infection source without treatment
- Patient has previously received treatment at the SPH Pain Clinic for the same issue and has not followed treatment recommendations
- Patient has previously completed pain group management programs in tertiary centres, counseling and/or interdisciplinary consult and there are no new pain management approaches available
- Initial request is related to preparation of a return to work report or other documentation that is provided on cost recovery basis
- Patient is currently attending another pain medicine program which offers same services (e.g. Canadian Pain & Regenerative Institute, CHANGEpain, Jim Pattison Outpatient Care Pain Clinic, Victoria or Nanaimo Pain Program, Bill Nelems Pain & Research Centre, BC Women's Hospital programs)
- Patient would be better referred to a tertiary pain clinic specializing in the primary reason for referral
    - Send referrals for pelvic pain and endometriosis to the Centre for Pelvic Pain & Endometriosis: www.bcwomens.ca/our-services/gynecology/pelvic-pain-endometriosis
    - Send referrals for myalgic encephalomyelitis/chronic fatigue syndrome, fibromyalgia or symptoms attributed to chronic Lyme disease to the Complex Chronic Diseases Program (CCDP): www.bcwomens.ca/our-services/specialized-services/complex-chronic-diseases-program

Print Clear

Providence Health Care

SPH PAIN CLINIC REFERRAL FORM

Phone: 604-806-8824
Fax: 604-806-9117

8342

Pain Referral

Date of referral:

Patient Name: (Print clearly or attach label) _____

Date of Birth: (dd/mm/yyyy) _____ PHN: (personal health number) _____

Preferred Phone: _____ Other Phone: _____ Email: _____

Address: _____

☐ WorkSafe BC Claim number _____ ☐ ICBC Claim number _____ Other Claim number _____

Interpreter required? ☐ No ☐ Yes Language: _____

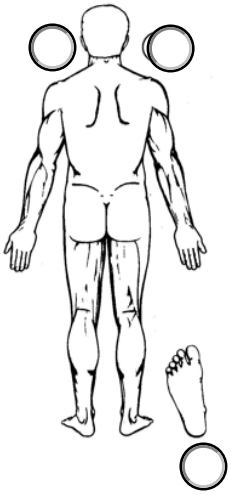
Referring Primary Care Provider: Name and specialty: _____ MSP number _____

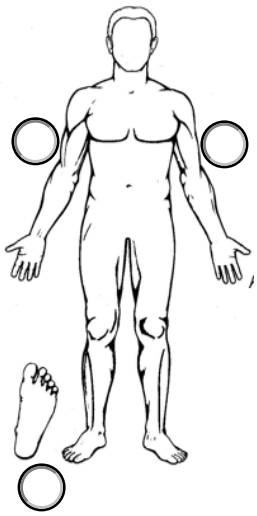
Phone: _____ Fax: _____

Primary Care Provider: Name: _____ MSP number _____

Phone: _____ Fax: _____

Area of Pain for Treatment (circle)





Urgency:

☐ Urgent (within 4 weeks) – Reason (*e.g. complex regional pain syndrome, acute post-operative pain*):
☐ Semi-Urgent (within approximately 6 months) – Reason:
☐ Elective (within approximately 6 to 12 months) – Reason:

Duration of pain:

☐ Less than 3 months
☐ 3 to 6 months
☐ More than 6 months

For more information, including inclusion/exclusion criteria, please visit our website: www.providencehealthcare.org/pain-outpatient-clinics

SPH PAIN CLINIC REFERRAL FORM
Phone: 604-806-8824
Fax: 604-806-9117

* 8 3 4 2 *

Pain Referral

Place Patient Label Here

Diagnosis of Complex Regional Pain Syndrome?

- ☐ No
- ☐ Yes: ☐ less than 12 months
  ☐ 12 months or more

Reason for Referral (check all that are applicable):

- ☐ Self-management/interdisciplinary programs
- ☐ Pain specialist consultation
- ☐ Request for specific intervention (specify): _____
- ☐ Additional details attached

History, Previous Treatment, and Goals of Treatment: (e.g. able to exercise again, able to do hobbies again)

Expectation: ☐ Multidisciplinary group ☐ Intervention ☐ Opinion only

DOCUMENT CHECKLIST

Our triaging physician MUST have the following documents to review this referral. If investigation is pending, please attach referral/requisition form.

	Report attached	Referral attached
• Complete current medication and allergy list	☐	☐
• Health history: physical exam results, medications tried, medical, surgical and psychiatric history	☐	☐
• Consultation notes from or referrals to specialists, including pain specialists	☐	☐
• Recent relevant investigations		
○ X-ray of specific joint being assessed (less than 12 months)	☐	☐
○ Nuclear medicine bone scan of pain area (less than 6 months, optional)	☐	☐
○ CT or MRI of spine (following onset of pain or change in symptoms; preferably less than 12 months)	☐	☐
○ CT or MRI of head (less than 24 months, required for headache patients)	☐	☐

☐ **I have read the description of the SPH Pain Clinic and reviewed the inclusion and exclusion criteria. The primary care provider is aware of this referral and has agreed to accept responsibility for ongoing care.**

Referring Provider:

Signature _____ Printed name _____ MSP # _____

FOR SPH PAIN CLINIC USE ONLY

This referral will be triaged. For prompt booking, please ensure all sections are fully completed.

Acknowledgement of referral (to be completed within 10 business days): This referral has been triaged and our office will contact your patient within the next _____ weeks / months (circle one) to make an appointment.

Your patient is booked to see a specialist on: Date: _____ Time: _____

- ☐ We will notify your patient
- ☐ We require additional info before we can book an appointment for this patient: _____

For more information, including inclusion/exclusion criteria, please visit our website: www.providencehealthcare.org/pain-outpatient-clinics