ST. PAUL'S PAIN CLINIC REFERRAL

Pain Referral

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

CLINIC DESCRIPTION:

- The multidisciplinary Pain Management Program is for patients requiring treatment for pain that has been unresponsive to conventional treatment
- 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
- Family/referring physicians agree to participate in the suggested regimen
- The clinic does **NOT** assume prescribing, including opioids; may provide physician to physician consultation on dosing

INCLUSION CRITERIA:

- Patient is 18 years of age or older
- Patient lives in Vancouver Coastal Health (VCH) Authority catchment. Exception: If the service is not offered in your health authority, we may accept the referral to be seen
- 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 is psychiatrically unstable (e.g. active psychosis, severe depression, actively suicidal)
- Patient has active untreated addiction
- Referral source's primary goal is medical legal consultation, or to obtain controlled substances
- Patient has an ongoing infection source without treatment
- Patient has previously received treatment at the SPH Pain Clinic for the same issue or 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 NAME: (Print clearly or attach label) ____

Surname Given Name Middle

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

Primary Phone: ____________________ Cell Phone: ______________ Email: ____________________

Address: ____

☐ WorkSafe BC Claim # ____________ ☐ ICBC Claim # ____________ Other Claim # ____________

Language: ______________________ ☐ Interpreter required

Referring Physician: (printed name) ______________________________________ MSP# ____________

Phone: ____________________________________ Fax: ________________________________

Family Physician: (printed name) ____ MSP# ____________

Phone ____________________________________ Fax ________________________________

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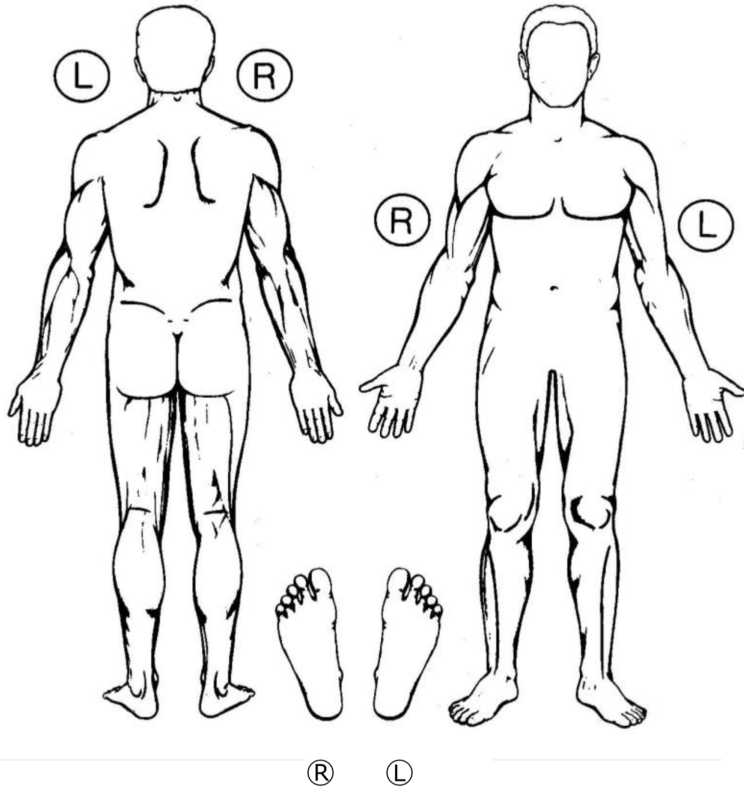
Area of Pain for treatment (circle)



Duration of pain:

☐ Less than 6 months ☐ 6 to 24 months
☐ More than 24 months

Diagnosis of Complex Regional Pain Syndrome?

☐ No ☐ Yes - ☐ Less than 12 months
☐ 12 months or more

Reason for Referral: (e.g. pain after car accident, impaired mobility)

Treatment goals: (e.g. able to exercise again, able to do hobbies again)

Our triaging physician MUST have the following documents attached to review this referral:

1. **Complete current medication list**
2. **Health History**
3. **Specialist consultation notes relevant to pain management (if available)**
4. **Recent relevant investigation (if available)**
   - X-ray and CBC (less than 12 months)
   - Nuclear medicine bone scan of pain area (less than 6 months)
   - CT or MRI (following onset of pain or change in symptoms; less than 24 months)
   - CT or MRI of head (less than 24 months)
   - X-ray cervical spine (less than 24 months)

I have read the clinic description of St. Paul's hospital Complex Pain Clinic and reviewed the inclusion and exclusion criteria. The family physician is aware of this referral and has agreed to accept responsibility for ongoing care.

REFERRING PHYSICIAN:

Signature	Printed name	MSP #