

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
<ul style="list-style-type: none"> • 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.) 	<ul style="list-style-type: none"> • 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	Previous Pain-related Assessments/Treatments
<input type="checkbox"/> Interprofessional pain management (medical doctor, nursing, occupational, physiotherapy, pharmacist, psychologist, social work) <input type="checkbox"/> Request for interventional pain management; Specify: _____ <input type="checkbox"/> Urgent: Complex Regional Pain Syndrome < 6 months <input type="checkbox"/> Urgent: Postherpetic neuralgia < 6 months <input type="checkbox"/> Transition from pediatric to adult chronic pain program <input type="checkbox"/> WSIB specialty clinic <input type="checkbox"/> WSIB claim # _____	<input type="checkbox"/> Has your patient been assessed by one of the Pain Management Program physicians in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Dr. _____ <input type="checkbox"/> Have there been other pain clinics or specialists consulted for this pain program? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which clinics: _____ <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Psychologist <input type="checkbox"/> Community chronic pain management group

***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

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Pharmacotherapy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hospital-based mental health services |
| <input type="checkbox"/> Anxiety: GAD/PTSD/Panic / Pain-related | <input type="checkbox"/> Community-based mental health services |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> FHT Social worker |
| <input type="checkbox"/> Symptoms poorly controlled * | <input type="checkbox"/> Community counselling agency |
| <input type="checkbox"/> Symptoms are severe, will impede treatment* | <input type="checkbox"/> Employee Assistance Program / Private Therapist |
| | <input type="checkbox"/> 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

- | | | |
|--|---|---|
| <input type="checkbox"/> Active substance abuse disorder | <input type="checkbox"/> Housing instability | <input type="checkbox"/> Visual/Hearing/Speech impairment |
| <input type="checkbox"/> Past substance use disorder | <input type="checkbox"/> Poverty | <input type="checkbox"/> Family planning/Pregnancy |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> No medication coverage | <input type="checkbox"/> Treatment noncompliance |
| <input type="checkbox"/> Cognitive impairment (Learning disability, developmental delay) | <input type="checkbox"/> Travel distance / cost | <input type="checkbox"/> 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