**Pain Management Program**

Patient Name:

Patient Health Card Number:

Patient Date of Birth:

**St. Joseph’s Hospital**

268 Grosvenor Street

London, Ontario N6A 4V2

519-646-6019

519-646-6292

**PHYSICIAN AGREEMENT LETTER**

Dear Doctor:

Your patient has been referred to the Pain Management Clinic of St. Joseph’s Health Care London either by you or another doctor. We look forward to offering our assistance. Our team will provide assessment and a care plan for the patient’s chronic pain problem. This may include pharmacologic planning and advice.

In our model of care, we require the support of primary care providers to either initiate trials of medications and/or take over prescribing medications that provide benefit once the patient’s pain is stabilized (6-24 months).

By requesting pharmacologic follow-up with the primary care providers, we hope to increase access to our clinic for new patients, decrease wait times, and improve the availability of resources that may not be available in your clinic, such as interventional techniques or psychology services. Medications that may be recommended or initiated by our clinic staff include pain active antidepressants, anticonvulsants, and controlled substances such as opioids and oral cannabinoids.

If you are not the primary care provider for the patient, please ensure this treatment agreement letter is sent to that physician to review. This letter must be signed and received by the pain clinic to accept the referral.

**Are you willing to prescribe medications recommended by the St. Joseph’s Pain Management Clinic physician including opioids and/or oral cannabinoids?**

**YES** check box **NO check box**

Physician Signature: Physician Name (please print):

Sincerely,

The Physicians at the St. Joseph’s Pain Management Clinic