

**Pain Management Centre
WRHN @ Chicopee
Outpatient Referral Form**

WRHN @ Chicopee
3570 King Street East, Kitchener, Ontario, N2A 2W1
PHONE: 519 749 4300 ext. 7860
FAX: 519 894 8310 (Please ensure to fax completed referral form, do not email)

Please note that all referrals must be completed on this form. Please provide as much detail as possible to ensure your patient is triaged appropriately.

We recommend non-urgent patients complete the Chronic Pain Self-Management Program.

For more information on the Program, please contact the Self-Management Coordinator at 1-866-337-3318 or visit the web site at www.wselfmanagement.ca

Criteria:

- The patient must have a primary care provider willing to follow her/him during and after discharge from the pain program
- The primary care provider must be willing to manage patient prescriptions
- Patients must be 18 years of age and older
- We do not address acute pain, chronic non-musculoskeletal pain, daily headache or fibromyalgia

Patient Identification

Last Name:	First Name:	Initial:	<input type="checkbox"/> Male <input type="checkbox"/> Female
DOB (year/month/day):	Health #:	Version Code:	
Street Address:	City:	Prov:	Postal Code:
Home Phone:	Cell Phone:		
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, language required:			

Please note: All patients must have a primary care provider

Physician Information

Referring Physician:	Referring Physician Billing #:
Referring Physician Phone #:	Referring Physician Fax:
Family Physician (if different from above):	Family Physician Billing #:
Family Physician Phone #:	Family Physician Fax:
Do you belong to a Family Health Team? <input type="checkbox"/> Yes <input type="checkbox"/> No Name:	

Please note: Pain Management Center will not take over prescribing of current medications

Clinical Information

Clinical question to be answered:	
Estimated pain problem start date (year/month/day): _____	
Duration of Pain Problem: (Please check appropriate box) <input type="checkbox"/> Less than 3 months <input type="checkbox"/> 3 – 6 months <input type="checkbox"/> More than 6 months	
Does the patient have: <input type="checkbox"/> Multiple areas of pain <input type="checkbox"/> Single focus of pain <input type="checkbox"/> Dermatomal distributions of pain	Purpose of Referral: <input type="checkbox"/> Consultation/provide advice <input type="checkbox"/> Treatment <input type="checkbox"/> Specific service requested: _____

Please check appropriate box

Urgent

- Complex Regional Pain Syndrome (CRPS) < 6 months
- Back Pain < 6 months
- Lumbar Radicular Pain < 6 months
- Cervical Radicular Pain < 6 Months

Non Urgent

- Complex Regional Pain Syndrome (CRPS) > 6 months
- Neuropathic Pain
- Back Pain > 6 months
- Lumbar Radicular Pain
- Neck Pain
- Cervical Radicular Pain
- Other: _____

Pain Diagnosis if available: _____

Musculoskeletal pain (Neck & Back)

Neck Pain

- Limb dominant
- Neck dominant
- Whiplash-associated disorder

- Failed back surgery syndrome
- Joint pain, *location* _____

Low back pain

- Limb dominant
- Back Dominant
- Non-mechanical back pain
- Sacro-iliac joint pain

Neuropathic pain

- Complex Regional Pain Syndrome

Patient has radicular pain? Yes No

Medical History

Attach all listed reports to referral

- Legible history of pain problem and previous medications tried for pain relief
- Medical History
- Allergies: _____

Height: _____ Weight: _____ BMI: _____

Currently on antiplatelet(s) Yes No anticoagulant(s) Yes No

Current medications and dosages: _____

Pain Investigations relevant to pain referral (within last 2 years) Please check and attach reports available:

- MRI CT EMG Ultrasound Emergency Department Chart
- Other: _____

Do they have significant depression and/or anxiety? Yes No If yes, treatment reports attached?

Any history of Drug/Alcohol abuse or addiction? Yes No If yes, treatment reports attached?

Other relative history: _____

Previous Pain Related Assessments: (please include reports)

- Psychologist
- Allied Health Professional (Social worker, Physiotherapist, Chiropractor etc.)
- Has this patient been evaluated by another pain specialist/ or receiving treatment at another pain clinic? Yes No
- Independent Medical Evaluation IME

Primary Care Provider Attestation

The consultants at the Waterloo Wellington Regional Pain Management Center at WRHN practice a shared care model. One of our admission criteria is that Family Physicians play an active role in the treatment of their patients. We will provide assessment and a treatment plan for your patient's chronic pain problem. In some cases, the treatment may be initiated by our clinic, however, once stabilized the patient will be returned to you for ongoing care. This includes ongoing Pharmacotherapy that may include opioids. If in agreement, please sign this form:

Family Physician

Date

Are you willing to prescribe **medications** / opioids for this patient if recommended? Yes No

If no, please provide reason: _____

If you require further information please contact the receptionist at the WW Regional Pain Management Center, at WRHN.