

Name
 Address
 Phone
 Phone
 DOB
 Health Card N°

Phone: 613.737.8949 Fax: 613.739.6296

Referring Clinician: _____ Primary Care Provider (If different from above): _____	Telephone:	Fax:
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DECLARATION AND CONSENT:

- Please ensure that sections ABCD are completed; otherwise, the referral will be declined.
- An option that may be presented following the referral is an eConsult with one of our pain medicine physicians.
- All patients referred require the ongoing support from the Primary Care Provider (PCP).
- Assessment, treatment and recommendations may be initiated by our clinic; however, once stabilized or optimized the patient will be discharged back to the PCP for ongoing care.
- It is the expectation that the PCP will be the sole prescriber of any recommended pharmacotherapy.
- The anticipated involvement with the Pain Clinic is one year.
- Our interprofessional team (occupational therapist, physiotherapist, psychologist and social worker) provide education, assessment, and treatment of chronic pain and common co-occurring problems. Our goal is to help people improve their day-to-day functioning and quality of life. Self-Management and Lifestyle improvement based on goal setting is a major component in our program and is integral to their success.
- I accept the above terms and conditions.

REQUIRED MEDICAL HISTORY (SECTION A)

Attach all listed reports to referral <input type="checkbox"/> Detailed history of pain condition <input type="checkbox"/> Medical history <input type="checkbox"/> Current medication and dosages <input type="checkbox"/> Previous treatments and medications tried for pain relief <input type="checkbox"/> If CRPS is the reason for the referral, please send completed Budapest criteria (See Appendix)	Mental Health diagnoses <input type="checkbox"/> Yes <input type="checkbox"/> No Current Mental Health provider <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reports available/attached
Investigations relevant to pain referral Please check and attach reports (within last 2 years) <input type="checkbox"/> CT <input type="checkbox"/> EMG <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other: _____	Current or historical Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reports available/attached

OTHER PAIN RELATED ASSESSMENT/TREATMENTS (SECTION B) Yes No

- Physical Interventions: _____
- Psychosocial interventions: _____
- Reports available/attached

Has your patient attended a Chronic Pain Community self-management program? Yes No
 Has your patient received treatment by another Pain Clinic? Yes No
 If yes, please specify whom: _____ Date: _____
 Reports available/attached

REQUIRED MEDICAL INFORMATION (SECTION C)

Pain Diagnoses:

Duration of Pain Condition (Please check appropriate box)

3-6 months
 6-18 months

Please check all that apply from our referral criteria below:

Palliative
 Complex Cancer Pain
 Pregnancy
 Radicular Symptoms
 Complex Regional Pain Syndrome (CRPS)

Neuropathic Pain
 Sickle Cell Anemia
 Post-Surgical Pain
 Spinal Cord Stimulator (SCS)
 Pediatric
 Referral suggested by TOH pain specialist during eConsult

Pain site (Please check all that apply)

Facial, Headaches
 Neck, Back, Spine
 Extremities
 Thoracic, Chest
 Gynecological Abdominal, Pelvic, Groin
 Non-Gynecological Abdominal, Pelvic, Groin

PATIENT NEEDS (SECTION D) Yes No

Your patient's preferred name is (if different from above): _____

Your patient's gender: _____

Your patient has communication and/or comprehension needs (interpreter required, learning disability, low literacy, visual impairment)

Your patient has barriers to care (transportation, access to technology for virtual care):

Please explain: _____

Appendix

Budapest Criteria for Complex Regional Pain Syndrome (CRPS)

To make the clinical diagnosis, the following criteria must be met:

- Continuing pain, which is disproportionate to any inciting event.
- Must report at least one symptom in all four of the following categories:
 - sensory – reports of hyperaesthesia and/or allodynia
 - vasomotor – reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry
 - sudomotor/oedema – reports of oedema and/or sweating changes and/or sweating asymmetry
 - motor/trophic – reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).
- Must display **at least one sign** at time of evaluation in two or more of the following categories:
 - sensory – evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement)
 - vasomotor – evidence of temperature asymmetry ($> 1\text{ }^{\circ}\text{C}$) and/or skin colour changes and/or asymmetry
 - sudomotor/oedema – evidence of oedema and/or sweating changes and/or sweating asymmetry
 - motor/trophic – evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)
- There is no other diagnosis that better explains the signs and symptoms.