The Ottawa Hospital | L'Hôpital d'Ottawa

Phone: 613.737.8949 Fax: 613.739.6296

Name

Address

Phone

Phone

DOB

Health Card N°

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

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
- ☐ Detailed history of pain condition
- ☐ Medical history
- ☐ Current medication and dosages
- ☐ Previous treatments and medications tried for pain relief
- ☐ If CRPS is the reason for the referral, please send completed Budapest criteria (See Appendix)

Mental Health diagnoses
☐ Yes ☐ No

Current Mental Health provider ☐ Yes ☐ No

☐ Reports available/attached

Investigations relevant to pain referral

Please check and attach reports (within last 2 years)
- ☐ CT
- ☐ EMG
- ☐ MRI
- ☐ Ultrasound
- ☐ Other: _____

Current or historical Substance Use ☐ Yes ☐ No

☐ 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: _____