Providence HEALTH CARE

# COMPLEX PAIN CENTRE REFERRAL

## GENERAL PROGRAM DESCRIPTION

The Interdisciplinary Pain Management Program is for patients requiring treatment of severe pain that has proven unresponsive to conventional approaches. Emphasis is placed on self-management and rehabilitation/ activation within the context of specialized medical assessments and treatments.

1. All patients will participate in an introductory education session and program orientation.
2. Consultations and visits may include both individual and group sessions, and will be individualized for each patient.
3. Disciplines involved with pain management in this program may include:
   - Anesthesiologists trained in interventional techniques
   - Psychiatry
   - Physical Medicine and Rehabilitation
   - Internal Medicine
   - Neurosurgery
   - Psychology
   - Nursing
   - Physiotherapy
   - Occupational Therapy
   - Social Work

**EXCLUSION CRITERIA**

- Psychiatric instability
- Actively abusing prescription or recreational drugs
- Primary goal is a medical-legal consultation, or to obtain "medical marijuana"
- Awaiting planned surgical treatment
- Chronic pelvic pain requiring further diagnostic clarification
- Cognitively unable to participate in a multidisciplinary assessment and treatment program
- Patient has an infection or significant communicable disease posing risk to staff and other patients

☐ New patient ☐ Re-referral

**PATIENT NAME:** _____ Gender: ☐ Male ☐ Female ☐ Transgender

Date of Birth: (dd/mmm/yyyy) _____ PHN #: _____

Address: _____

Phone: Home: _____ Cell: _____

Work: _____

The treatment provided by the Complex Pain Centre is specialized and is not open-ended. Patients must be followed by their family physicians during and after their participat**ion in the p**rogram. The program is offered to patients living within the catchment area of Providence Health Care and the Vancouver Coastal Health Authority with some rare exceptions for those living outside this area.

**DATE OF REFERRAL:** _____

**REFERRING MD:** _____

Phone: _____ Fax: _____

Area of Expertise: _____ ☐ Specialist ☐ GP

GP: (if not referring MD) _____

Phone: _____ Fax: _____

**I have read the program description of the St. Paul's Hospital Complex Pain Centre and acknowledge that it is a time-limited program. In referring this patient, I agree to accept responsibility for ongoing care once this patient is discharged from the Complex Pain Centre. I acknowledge that this may include prescribing opioid(s) and other pain-modifying medications.**

Signature of Referring MD | Printed Name | MSP Billing No.

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## PATIENT PAIN HISTORY

**PRIMARY PAIN DIAGNOSIS:** (confirmed or suspected):

- ☐ Musculoskeletal pain
- ☐ Cancer pain
- ☐ Low back pain WITH radiculopathy
- ☐ Chronic daily headache
- ☐ Arthritis (osteo or rheumatoid)
- ☐ Low back pain WITHOUT radiculopathy
- ☐ Migraine headache
- ☐ Neuropathic pain
- ☐ Fibromyalgia or Myofascial Pain Syndrome
- ☐ Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)
- ☐ Temporomandibular joint pain
- ☐ Other: _____
- ☐ Unknown: _____

**DURATION OF PAIN:** (IMPORTANT) _____

**WHAT IS YOUR REASON FOR REFERRING YOUR PATIENT TO THIS PROGRAM?** Please be specific

_____

_____

_____

_____

**Is your patient interested in learning how to self-manage pain?** ☐ Yes ☐ No ☐ Maybe

**WORK HISTORY**

Patient Occupation: _____

- ☐ Working
- ☐ Wishing to return to work
- ☐ Not working due to pain
- ☐ Student
- ☐ Retired
- ☐ Not working due to other reason - Please clarify: _____

**ACTIVITIES OF DAILY LIVING:**

- ☐ No issues
- ☐ Coping adequately
- ☐ Struggling to cope

**LIVING SITUATION:**

- ☐ Alone
- ☐ With family
- ☐ Partner/Spouse
- ☐ Supportive housing
- ☐ Shelter
- ☐ Facility: _____
- ☐ Subsidized housing
- ☐ Other: _____

**PSYCHIATRIC HISTORY:**

- ☐ Anxiety disorder
- ☐ Mood disorder PHQ-9 _____
- Previous psychiatric admits: ☐ No ☐ Yes - Dates: _____
- ☐ Psychotic disorder
- ☐ Personality disorder
- Is the patient being followed by a Mental Health Team? ☐ No ☐ Yes
- ☐ Other: _____
- Mental Health Team name: _____

Psychiatrist currently providing care: ☐ No ☐ Yes Psychiatrist's name: _____

**ADDICTION CONCERNS:** ☐ Past history ☐ Active issue

Addiction behavior: (e.g. Gambling) ☐ No ☐ Yes - specify: _____

Addiction treatment: ☐ No ☐ Yes - specify: _____

Alcohol use: ☐ No ☐ Yes – specify how much & often _____

Recreational drugs: ☐ No ☐ Yes - specify: _____

Prescription drugs: (e.g. opioids, benzodiazepines) ☐ No ☐ Yes - specify: _____

Details: _____

_____

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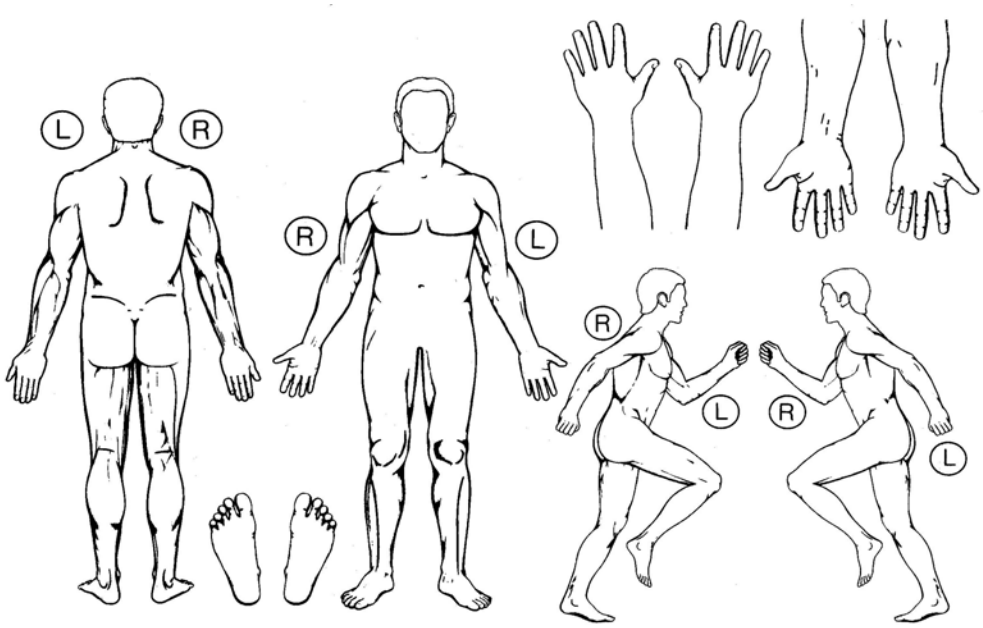
**PAIN DIAGRAM: Location of Pain**




**BRIEF PAIN HISTORY: Inciting Event**

☐ MVA Date: _____ ICBC case: ☐ Yes ☐ No

☐ Workplace injury _____ WorkSafeBC (WCB): ☐ Yes # _____

☐ Other injury: _____

☐ Post surgery _____

☐ Post illness _____

☐ Other: _____

**MEDICAL HISTORY:**

| | | |
|---|---|---|
| ☐ Stroke | ☐ Heart disease | ☐ Urological issues - specify: _____ |
| ☐ Traumatic brain injury | ☐ COPD/Emphysema | ☐ Gynecological issues - specify: _____ |
| ☐ Vision impairment | ☐ Diabetes | ☐ Gastrointestinal issues - specify: _____ |
| ☐ Hearing impairment | ☐ Kidney disease/Dialysis | ☐ Cancer - specify: _____ |
| ☐ Hypertension | ☐ Liver disease | ☐ Autoimmune disorder - specify: _____ |

☐ Other: _____

_____

**PAST TREATMENT HISTORY:**

Single Modality Rehabilitation:

☐ Occupational therapy
☐ Physiotherapy
☐ Chiropractic
☐ Massage therapy

Alternative Treatments:

☐ Naturopathy
☐ Acupuncture

Other: (specify) _____

_____

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Multidisciplinary Rehabilitation:

Specify program: _____

Facility: _____

Surgery: (specify and provide date)

_____

Procedural Treatments:

☐ Epidurals ☐ Trigger point injections

☐ Sympathetic blocks ☐ Other: (specify) _____

Psychological Treatments:

☐ Details: _____

**PREVIOUS INVESTIGATIONS AND CONSULTATIONS:** (attach all reports)

We expect that all appropriate initial investigations have already been performed by the referring doctor.

| Imaging: | Date |
|---|---|
| ☐ CT scan | _____ |
| ☐ X-ray | _____ |
| ☐ MRI | _____ |
| ☐ Bone scan | _____ |

☐ Specialist consult reports (including surgical reports) _____

☐ Lab work _____

☐ Physiotherapy/Occupational Therapy Assessment

**MEDICATION TRIALS:** (Specify medication name, dosage and if discontinued the reason)

☐ NSAIDs/Acetaminophen: _____

☐ Anti-depressants: _____

☐ Opiates: _____

☐ Anti-convulsants: _____

Other: _____

IMPORTANT: **Include a printout of patient's CURRENT medications in the referral package**

REFERRAL DOCUMENT CHECK LIST:

☐ Complete ALL PAGES of the Referral form including Patient Pain History. **PLEASE PRINT CLEARLY**

☐ Include a minimum of 2 DIFFERENT specialist consult reports, related to the pain issue.

☐ Include any relevant diagnostic tests (see below)

1. All patients with spinal pain: A recent (within last 6 months) bone scan, plain X-Ray and CBC
2. Provide a recent (within last 18 months) CT or MRI of the appropriate area for all patients over 60 years old, ∗**OR**∗ with history of malignancy, ∗**OR**∗ radicular pain (pain radiating down a limb).
3. Provide a recent (within last 2 years) neurological consultation and CT or MRI of the cervical spine for all patients referred for chronic headaches.

☐ Include any additional consultation reports and investigations

☐ Include a printout of patient's CURRENT medications

**FAX COMPLETED REFERRAL PACKAGE TO 604-806-8782**

IMPORTANT: If pertinent information is missing, the referral will be returned to you and your patient will not be waitlisted. We will contact the patient directly to set-up an appointment.