

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 OHIP referred patients complete the Chronic Pain Self Management Program.

Completed Currently Attending Registered Other _____

For more information on the Program, please contact the Self Management Coordinator at 1-855-333-2376 or visit the web site at www.takecontroldatakecharge.ca

PATIENT INFORMATION

Surname:		Given Name:	
DOB:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Address:			
Telephone #:		Email Address:	
Health Card Number:			

PHYSICIAN INFORMATION:

Referring Physician:	Telephone #:	Fax #:	
Referring Physician Billing #:	Do you belong to a Family Health Team? Yes <input type="checkbox"/>		No <input type="checkbox"/>
Family Physician (if different from above):	Telephone #:	Fax #:	
Family Physician Billing #:	Number of years patient with Family Physician:		

TREATMENT OPTIONS? (Please check appropriate box):

OHIP FUNDED:

NEW! All new patients will have an Allied Health Assessment (to determine suitability for educational interdisciplinary groups)

- Assess the patient and suggest a treatment plan for me to follow
- Technical referral ex: Epidural, Stellate Block, Facet/SI Joint Injections
- Other _____

THIRD PARTY FUNDED: Patient must be able to converse in English, work in groups, be cooperative, and be independent in self-care i.e. personal care, etc.

- Interdisciplinary Assessment (to determine suitability for cognitive/behavioural interdisciplinary group program)
The patient is seen by a pain physician, psychologist, and an allied health professional
- Other _____

THIRD PARTY FUNDING AGENCY INFORMATION

- WSIB - Claim # _____ Department of National Defense - M# _____
- Motor Vehicle Accident - Claim # _____ Employer _____
- Veteran Affairs - K# _____ Other _____

When we receive the referral we will assist your patient with the funding approval. If you have any questions regarding funding please contact **Sonya Altena** at 905-521-2100, Ext. 74342 or by email altena@hhsc.ca

CLINICAL INFORMATION

Pain Diagnosis if available: _____

Duration of Pain Problem: (Please check appropriate box)

-
- Less than 3 months
-
- 3 - 6 months
-
- More than 6 months

Please check appropriate box**Urgent**

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

Non Urgent

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

MEDICAL HISTORY**Attach all listed reports to referral**

-
- Legible history of pain problem
-
-
- Medical history including allergies, Height _____ Weight _____ BMI _____
-
-
- Current medications and dosages
-
-
- Previous medications tried for pain relief

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

-
- MRI
-
- CT
-
- EMG
-
- Ultrasound
-
- 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? **Please have the patient complete the following screening tools (available on [website](#)) and attach to referral.**

-
- Brief Pain Inventory
-
- S-LANSS
-
- PHQ-4
-
- PCS
-
- TSK
-
- PSEQ

PREVIOUS PAIN RELATED ASSESSMENTS / TREATMENTS: (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?
-
-
- Independent Medical Evaluation IME

Consultants at the Michael G. DeGroot Pain Clinic practice on 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 patients 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 opioids for this patient if recommended? YES NO If No please provide reason:

If you require further information please contact: Sandra MacDuff RN, BScN, P: 905-521-2100 ext. 42590