VANCOUVER ISLAND health authority

# REGIONAL OUTPATIENT PAIN MANAGEMENT PROGRAM REFERRAL FORM

**Please choose one only:** ☐ **Royal Jubilee Hospital Site** ☐ **Nanaimo Regional General Hospital Site**

**Patient Name:** ______________________________________________ ☐ **New Patient** ☐ **Re-referral**
**(Please Print Clearly or attach label)** Surname Given Name Middle **Date of Referral:** ________________

**Address:** ____________________________________________________________________________

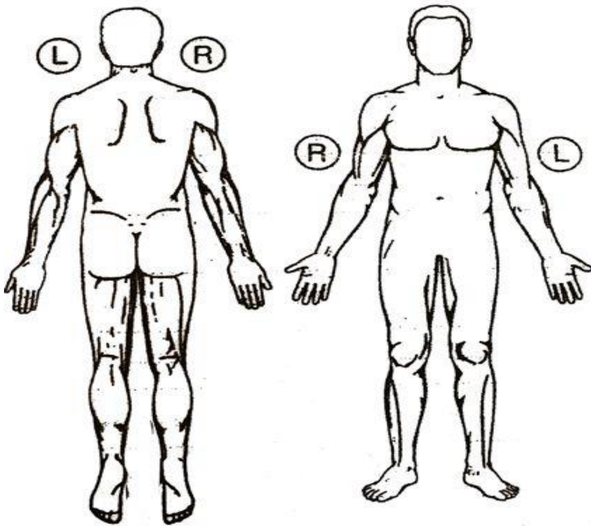
**Date of Birth:** ____________________ (dd/mm/yyyy) PHN (Personal Health Number): ___________________________

**Daytime Phone:** __________________**Cell Phone:** _________________________ **E-mail Address:** __________________

**Referring Physician:** ___________________________ **MSP#:** _________ Phone: _______________ Fax: _______________
Please Print Name

**Referring Physician:** ________________________ **Primary Care Physician:** _____________________ Phone: ___________
Signature

**AREA OF PAIN FOR TREATMENT**




1. **Reason for referral** (check all that are applicable)
   - ☐ **Self-management/programs**
   - ☐ **Interdisciplinary team**
   - ☐ **Physician pain specialist**
2. **Pain Description:**

_______________________________________________

_______________________________________________

_______________________________________________

3. **Duration of pain:** ____________**(IMPORTANT)**

**∗∗ Please note:**

- ∗ **Interventionalist will treat only one area of pain per referral.**
- ∗ **New referral must be submitted for <u>each</u> diagnosis.**

| **PLEASE ANSWER <u>ALL</u> THE QUESTIONS** **(Referrals will NOT be processed if incomplete)** | Y | N | 6. Is the patient aware and agreeable to this referral? | Y | N |
|---|---|---|---|---|---|
| 1. Is the patient scheduled for surgery related to the pain problem? | | | 7. Is the pain related to an active ICBC claim? | | |
| 2. Does the patient have poorly controlled psychopathology (psychosis, suicidal etc)? | | | 8. Is the pain related to an active WCB, DND or other 3rd Party Claim?<br>9. IF YES, CLAIM #_______________________ | | |
| 3. Does the patient have untreated/ongoing substance abuse/addiction? | | | 10. Any legal action related to the pain problem? | | |
| 4. Does the patient have a significant needle fear (fainting, panic attacks etc)? | | | 11. Have appropriate diagnostic tests been done? (See Diagnostic Tests below). **PLEASE ATTACH RESULTS.** | | |
| 5. Is the patient willing to have interventional (injection) treatments? | | | 12. Does the patient have a significant communicable disease (Hepatitis, HIV, TB etc)? | | |

**<u>DIAGNOSTIC TESTS (to be completed prior to accepting referral)</u>:**

1. All spinal pain: Recent (< 6 months) Bone scan, plain X-Ray and CBC.
2. All patients over 60 years old, OR a history of a significant malignancy, OR radicular pain (pain radiating down a limb) recent (< 18months) CT or MRI of appropriate area.
3. All patients referred for Chronic Headaches: Recent (< 2yrs) Neurological Assessment and recent (<2yrs) CT Cervical spine.

**Please attach:**

1. **Complete medication list including Coumadin, Plavix, ASA, Opiates**
2. **All pertinent scans (CT, MRI, X-ray, and bone scans).**
3. **All pertinent consults from other physicians including surgical reports.**

***<u>An incomplete referral will not be processed and will be returned by fax.</u>***

**Thank you, Pain Management Team**

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|---|---|---|---|
| **PAIN PROGRAM WEBSITE:** | http://www.viha.ca/pain_program | | |
| **PAIN PROGRAM EMAIL ADDRESS:** | PainProgram@viha.ca | | |
| **PAIN CLINIC CONTACT NUMBERS:** | RJH | Pain Clinic, Memorial Pavilion: | Tel: (250) 519-1836 |
| | | Fax number: | Fax: (250) 519-1837 |
| | NRGH | Pain Clinic: | Tel: (250) 739-5978 |
| | | Fax number: | Fax: (250) 739-5989 |
| **COMMUNITY PAIN SERVICE SUPPORT:** | Comox Valley Community Nursing Centre: | | Tel: (250) 331-8502 |
| | | Fax number: | Fax: (250) 331-8503 |

***WHEN POSSIBLE, PLEASE SEND REFERRALS THROUGH INTER-HOSPITAL MAIL.***

**Please tell patients NOT to call the Pain Program;**
**we will contact them when they have been approved through the referral process.**

**THANK YOU FOR YOUR CONTINUED SUPPORT.**