GRAND RIVER HOSPITAL
Advancing Exceptional Care

Pain Management Centre
Freeport Campus
Outpatient Referral Form

Freeport Campus, Grand River Hospital
3570 King Street East, Kitchener, Ontario, N2A 2W1
PHONE: 519-749-4300 ext. 7860
FAX: 519-894-8310 (Please ensure to fax completed referral form, do not email)

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 patients complete the Chronic Pain Self-Management Program.
For more information on the Program, please contact the Self-Management Coordinator at 1-866-337-3318 or visit the web site at www.wwselfmanagement.ca

Criteria:
- The patient must have a primary care provider willing to follow her/him during and after discharge from the pain program
- The primary care provider must be willing to manage patient prescriptions
- Patients must be 18 years of age and older
- We do not address acute pain, chronic non-musculoskeletal pain, daily headache or fibromyalgia

Patient Identification

Last Name:	First Name:	Initial:	❑ Male ❑ Female
DOB (year/month/day):	Health #:	Version Code:	
Street Address:	City:	Prov:	Postal Code:
Home Phone:	Cell Phone:		
Interpreter required? ❑ Yes ❑ No If yes, language required:			

Please note: All patients must have a primary care provider

Physician Information

Referring Physician:	Referring Physician Billing #:
Referring Physician Phone #:	Referring Physician Fax:
Family Physician (if different from above):	Family Physician Billing #:
Family Physician Phone #:	Family Physician Fax:
Do you belong to a Family Health Team? ❑ Yes ❑ No Name:	

Please note: Pain Management Center will not take over prescribing of current medications

Clinical Information

Clinical question to be answered:

Estimated pain problem start date (year/month/day): ______________________________________

Duration of Pain Problem: (Please check appropriate box)

❑ Less than 3 months ❑ 3 – 6 months ❑ More than 6 months

Does the patient have:	Purpose of Referral:
❑ Multiple areas of pain	❑ Consultation/provide advice
❑ Single focus of pain	❑ Treatment
❑ Dermatomal distributions of pain	❑ Specific service requested: ___________________________

Please check appropriate box	
Urgent ❑ Complex Regional Pain Syndrome (CRPS) < 6 months ❑ Back Pain < 6 months ❑ Lumbar Radicular Pain < 6 months ❑ Cervical Radicular Pain < 6 Months	**Non Urgent** ❑ Complex Regional Pain Syndrome (CRPS) > 6 months ❑ Neuropathic Pain ❑ Back Pain > 6 months ❑ Lumbar Radicular Pain ❑ Neck Pain ❑ Cervical Radicular Pain ❑ Other: ____
Pain Diagnosis if available: _______________________________________	
Musculoskeletal pain (Neck & Back) Neck Pain ❑ Limb dominant ❑ Neck dominant ❑ Whiplash-associated disorder ❑ Failed back surgery syndrome ❑ Joint pain, *location* ______________________________	Low back pain ❑ Limb dominant ❑ Back Dominant ❑ Non-mechanical back pain ❑ Sacro-iliac joint pain Neuropathic pain ❑ Complex Regional Pain Syndrome
Patient has radicular pain? ❑ Yes ❑ No	

Medical History

Attach all listed reports to referral

❑ Legible history of pain problem and previous medications tried for pain relief
❑ Medical History
❑ Allergies: ____

❑ Height: ______________ ❑ Weight: ____________________ ❑ BMI: _________________________

❑ Currently on antiplatelet(s) ❑ Yes ❑ No anticoagulant(s) ❑ Yes ❑ No

❑ Current medications and dosages: ____

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

❑ MRI ❑ CT ❑ EMG ❑ Ultrasound ❑ Emergency Department Chart
❑ 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? ❑

Other relative history: ____

Previous Pain Related Assessments: (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? ❑ Yes ❑ No
❑ Independent Medical Evaluation IME

Primary Care Provider Attestation

The consultants at the Waterloo Wellington Regional Pain Management Center at Freeport practice 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 patient's 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 **medications /** opioids for this patient if recommended? ❑ Yes ❑ No

If no, please provide reason: ____

If you require further information please contact the receptionist at the WW Regional Pain Management Center, at Freeport.