Integrated Chronic Pain Program
Referral Form
865 Regent St South - 4th Floor
Sudbury, ON P3E 3Y9
Phone: 705-523-7100 ext. 2755
Fax: 705-671-5678
chronicpain@hsnsudbury.ca

In efforts to deliver the most effective model of care for patients suffering from chronic pain, patients being referred for medical intervention or medication changes alone or if patients are unwilling unable to participate in ANY OTHER intervention of the program other than medical intervention or medication changes, patients will not be accepted to be enrolled in HSN's Integrated Chronic Pain Program.

The Integrated Chronic Pain Program does not accept referrals for patients who have a current WSIB or MVC claim or appeal.

This program integrates an interprofessional team, with a focus on self-management and setting functional goals. The patients participating in programming will be expected to have an active role in their care.

PATIENT DEMOGRAPHICS

Patient Name:	HCN:
Date of birth (DD/MM/YYYY):	Gender:
Address:	Language:
Postal Code:	City:
Home Phone #:	Cell Phone #:

In our model of care, primary care providers (PCP) play an active role in the treatment of their patients. We will provide an assessment and recommended treatment plan for patient's chronic pain problem. In some cases, treatment may be initiated by our clinic, however, once stabilized, the patient will be returned to you for ongoing care, including pharmacotherapy.
Physicians working in the Integrated Chronic Pain Program will not take over prescribing or primary care responsibilities.
Please check box to indicate PCP has read and agreed with the above statement ☐ I agree

REFERRING HEALTH CARE PROVIDER INFORMATION

Primary Care Provider:	Fax #:
Address:	Phone #:
Billing Number:	
Family Physician/Primary Care Provider (if different from above):	

Legend: HCN - Health Card number

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CLINICAL INFORMATION

Referral diagnosis if available:

Duration of pain: ☐ Less than 3 months ☐ 3 - 6 months ☐ More than 6 months

Degree of functional impairment:

☐ Mild impairment (brief difficulties at home/work)

☐ Moderate impairment (ongoing difficulties at home/work, social activities and psychological symptoms)

☐ Severe impairment (severe/ persistent difficulties, not able to work, no social activities and psychological symptoms)

Please check all that apply:

Headache

☐ Cluster headache
☐ Migraine tension type headache
☐ Occipital neuralgia
☐ Temporomandibular joint disorder
☐ Trigeminal nerve pain

Musculoskeletal pain

☐ Failed back surgery syndrome
☐ Joint pain, location
Click here to enter text.

Low back pain

☐ Limb dominant
☐ Back dominant
☐ Non mechanical back pain

Neck Pain

☐ Limb dominant
☐ Neck dominant

☐ Sacro-iliac joint pain
☐ Whiplash-associated disorder

☐ Abdominal pain
☐ Post thoracotomy/Chest wall pain

Pelvic pain

☐ Chronic pelvic pain
☐ Endometriosis

Widespread pain disorders

☐ Fibromyalgia
☐ Myofascial pain syndrome
☐ Chronic fatigue syndrome

Neuropathic pain

☐ Complex Regional Pain Syndrome (EMG)
☐ Multiple Sclerosis
☐ Phantom limb pain (amputation less than 2 years)
☐ Shingles and post herpetic neuralgia
☐ Traumatic nerve injury
☐ Trigeminal neuralgia and atypical face pain

Other

☐ Cancer pain ☐ Cancer pain (palliative)

SRCPPREF

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HEALTH STATUS

- Is the individual medically stable and able to learn, engage with others and participate in gentle movement? ☐ Yes ☐ No Comment:
- Is the individual able to participate in aerobic/muscle strengthening exercises? ☐ Yes ☐ No
- Recommendations/restriction for exercise:
- Is the patient aware of and willing to participate in group based programming? ☐ Yes ☐ No
- Are there any other barriers to participation in the group based programing? ☐ Yes ☐ No
  Please clarify:
- Please describe patient's current mental health status:

PREVIOUS PAIN RELATED ASSESSMENTS/TREATMENTS

☐ Evaluated by another pain specialist or pain clinic?	When: Provider:
☐ Previous nerve block	When: Provider:
☐ Psychologist	☐ Physiotherapy
☐ Social Work	☐ Massage therapy
☐ Acupuncture	☐ Chiropractor
☐ Surgery	☐ Other:

Requirements (attach to referral)

☐ Medical history / Psychiatric history	☐ Medication reconciliation
☐ Relevant reports and imaging within 2 years	☐ Previous medications tried for pain relief

Only completed referral form will be accepted

Once referred, the patient will undergo an initial health and psychosocial assessment to assist in creating a treatment plan.

Please identify if your patient has specific goals of treatment:

DATE:_____ REFERRING SIGNATURE: _____

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