



Adult Chronic Pain Specialist Referral

Place Patient Label Here

Please fax completed form to Alberta Health Services Central Access – Edmonton Zone

Fax: 780-735-3553

Toll Free Fax: 1-866-979-3553

Phone: 780-401-2665

Mandatory Data Required for Processing Referral *(Missing or incomplete information will delay processing)*

- Client name and demographics
- Family physician name
- Reason for referral

Client Demographics

Name *(last)* _____ *(first)* _____

Street address _____ City _____ Postal Code _____

Home phone _____ Alternate phone _____

PHN _____ Gender M F Date of birth *(yyyy-Mon-dd)* _____

Referring Source *(MD and/or Nurse Practitioner)*

Name _____

Phone _____

Fax _____

PRACID # _____

Family Physician *(If different than referring source)*

Name _____

Phone _____

Fax _____

Is this an active WCB patient? Yes No

Attach pertinent consultation and imaging reports that are NOT available on netCARE

(e.g., previous pain programming, relevant specialist consultations, x-ray, MRI, etc.)

Reason for referral:

- Emerging pain condition** — relatively uncomplicated medication profile; limited impairment and duration, but single treatment/therapies have been ineffective. Patient would benefit from an assessment, education, and possibly specialized treatment.
- Debilitating and complex pain** — and/or significant behavioural/emotional involvement; a complex medication profile and/or an addiction. Patient likely requires highly specialized medical intervention and/or multidisciplinary programming.

History of Present Condition *Patient currently displays the following due to pain:*

- Decreased physical conditioning
- Decreased ability to complete ADLs
- Disability that exceeds clinical findings
- Disrupted sleep
- Increased medical/health services utilization
- Medication tolerance and/or mismanagement
- Significant activity restriction/reduced vocational abilities
- Significant mood disturbance e.g. anxiety, depression

What are the patient's key issues at present? _____

Adult Chronic Pain Specialist Referral

Place Patient Label Here

Diagnoses and Syndromes Mark (✓) all diagnoses/syndromes that apply and **circle** the most disabling at present

- | | |
|--|---|
| <input type="checkbox"/> Low Back Pain <u>with</u> radiculopathy | <input type="checkbox"/> Complex Regional Pain Syndrome (Formerly known as RSD) |
| <input type="checkbox"/> Low Back Pain <u>without</u> radiculopathy | <input type="checkbox"/> Arthritis (osteoarthritis, rheumatoid arthritis) |
| <input type="checkbox"/> Herpetic Neuralgia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Temporomandibular joint dysfunction/pain | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Spondyloarthropathies (i.e. ankylosing spondylitis) | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Myofascial pain syndrome | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fibromyalgia | |

How long has this patient been in pain?

- Less than 6 weeks Less than 3 months 3 to 6 months 6 to 12 months more than 1 year

Past Treatment History

What treatment strategies have been attempted for the most disabling diagnosis circled above?

- | | |
|--|---|
| <input type="checkbox"/> Single modality rehabilitation (OT, PT, chiropractic) | <input type="checkbox"/> Epidurals |
| <input type="checkbox"/> Multidisciplinary rehabilitation | <input type="checkbox"/> Sympathetic blocks |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Somatic nerve blocks |
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Trigger point injections |
| <input type="checkbox"/> NSAID's | <input type="checkbox"/> Alternative treatments _____ |
| <input type="checkbox"/> TCA's | <input type="checkbox"/> Surgery _____ |
| <input type="checkbox"/> Opioids | <input type="checkbox"/> Other _____ |

Desired Outcome of pain specialist consultation _____

Preferred Pain Specialist None Dr. _____

Note: Indicating a preference may impact your patient's wait time.

Has your patient previously been assessed and/or treated at a chronic pain facility in Edmonton?

- Yes No *(If Yes, please specify location and dates)* _____

Special Requirements

- Hearing, visual impairment requires oxygen, etc.
Please specify _____
- Cognitive impairment.
Please describe _____
- Unable to read or speak English. *Please specify language* _____
Translator/contact person _____ Phone number _____