Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Patient Name:

Date of Birth (yyyy/mm/dd):

Health Card:

CR:

Address:
Phone - Home:
- Work:
- Cell:

Chronic Pain Clinic Referral

Telephone: 613-544-3400 Extension 2315
Facsimile: 613-544-9638
Web: www.hoteldieu.com

The Referral must be complete to ensure appropriate and timely triage.
Please ensure your patient knows they will be required to fill out a "Self-Report Pain Questionnaire" at every appointment.

Referring Clinician: *(Print Name)* _____ Telephone: _____ Fax: _____

Specialty _____

Primary Care Provider (if different from above): _____ Telephone: _____ Fax: _____

Part of a Primary Care Team Practice? ☐ Yes ☐ No Years patient with Primary Care Provider: _____

We are a consult service. We provide assessments and treatment recommendations. Treatment may be initiated by our clinic; however, once stabilized the patient will be discharged and returned to the referrer for ongoing care. This includes the transfer of ongoing Pharmacotherapy.

Patients and/or caregivers must be capable and willing to participate with suggested regimen of therapy. Patients who are not adherent to regimen of therapy will be discharged from the clinic. Please note: we do not treat patients whose sole referral is for misuse of controlled substances or managing a diagnosed controlled substance addiction. Patients assessed as having untreated/uncontrolled misuse of controlled substances, or uncontrolled mental illness leaving them unable to comply with a pain management regimen, will be redirected back to referrer and/or other appropriate care pathway.

REQUIRED MEDICAL HISTORY

Attach all listed reports to referral

- ☐ Legible history of pain condition
- ☐ Medical history including allergies
- ☐ Current medications and dosages
- ☐ Previous treatments/medications tried for pain relief

Height _____ cm

Weight _____ kg

BMI _____

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

☐ MRI ☐ CT ☐ EMG
☐ Ultrasound ☐ Other

Significant depression and/or anxiety? ☐ Yes ☐ No
Poorly controlled psychopathology? ☐ Yes ☐ No
Reports available/attached? ☐ Yes ☐ No

Any history of Drug/Alcohol misuse?
☐ Yes ☐ No ☐ Reports available/attached

OTHER PAIN RELATED ASSESSMENTS / TREATMENTS: REPORTS ATTACHED ☐ Yes ☐ No

☐ Independent Medical Evaluation (IME) ☐ Physical Intervention (Physiotherapist/Occupational Therapist/Social Work)

☐ Psychological Intervention (Psychologist / Social worker) ☐ Other _____

Has your patient been directed to attend a chronic pain community self-management group? ☐ Yes ☐ No

If Yes, did they attend? ☐ Yes ☐ No

Has your patient been referred/evaluated or received treatment by another specialist/pain clinic? ☐ Yes ☐ No

If Yes, please specify whom: _____ Date: (yyyy/mm/dd) _____

_____ Date: (yyyy/mm/dd) _____

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New! Patients will be required to attend an information session as step one in the initial appointment process, and a preliminary Education Session prior to their first assessment.

Interdisciplinary group sessions focusing on tools and techniques to assist with **Self-Management and Lifestyle** improvement **may also be a requirement** of your patient's care plan.

REQUIRED CLINICAL INFORMATION

Pain Diagnosis if available:

Onset of Pain
Date (yyyy/mm/dd): _____

Duration of Pain Condition (Please check appropriate box)
☐ 3 – 6 months ☐ 6 – 18 months ☐ Other

Please check appropriate box

☐ Abdominal Pain
☐ Cancer
☐ Facial Pain
☐ Headache
☐ Pelvic Pain
☐ Myofascial Pain
☐ Neuropathic
☐ Fibromyalgia / Widespread Pain
☐ Complex Regional Pain Syndrome
☐ Cervical / Neck Pain
☐ Thoracic / Chest Pain
☐ Lumbar / Low Back Pain
☐ Radicular Symptoms
☐ Radicular Symptoms
☐ Radicular Symptoms

PATIENT EMPLOYMENT OVERVIEW

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Canada Pension Plan income only

Current/Previous Occupation: _____ Last Date Employed: _____ yyyy/mm/dd

Disability Insurance: ☐ None ☐ ODSP ☐ WSIB ☐ DND ☐ Private Disability _____
☐ Corrections Canada ☐ Ontario Works ☐ Other _____

Any Legal Action Pending? ☐ Yes ☐ No

REASON FOR REFERRAL

☐ **Interdisciplinary Chronic Pain Self-Management Program** (See website for program overview)
- ❖ this Self-Management Program is available to referring clinicians as a choice for sole purpose of referral

☐ **Evaluate current pain diagnosis and suggest a treatment plan**

☐ **Other** _____

PATIENT NEEDS / CONCERNS

☐ Communication and/or comprehension (interpreter required, learning disability, low literacy, visual impairment)
☐ Treatment Adherence Concerns (non-compliance with appointments and/or previous treatment recommendations)

Please specify: _____