changepain

REFERRAL FORM

FAX REFERRAL TO: 604-566-9102

Referral Date (DD/MM/YY)	**Referral Type**		
	☐ **New Referral**	☐ **Re-Referral** *(Patient discharged or last seen more than 6 months ago)*	☐ **Urgent Referral** *(Please see the criteria for urgent referral on page 2.)*
If Re-Referral, please provide a reason			

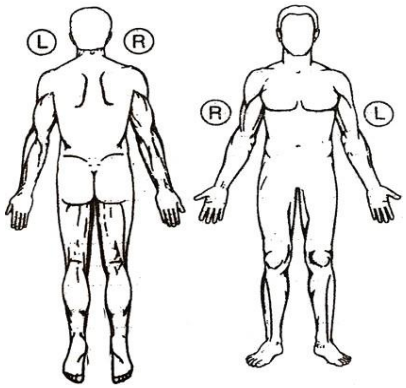
Important Instructions: *We expect that all appropriate initial investigations have already been performed by the referring physician. If the information is missing, the referral will be **rejected**, and the patient will **not** be wait-listed. We will contact the patient directly to set up an appointment. Please **do not** instruct patients to call regarding their consult appointment.*

	Name	**MSP Billing #**	**Phone**	**Fax**
Referring Physician				
Primary Care Physician				
Walk-In Clinic *(In case there is no Primary Care Physician)*				

Patient Information		***section must be completed**	
Name		**Gender**	
DOB		**PHN#**	
Address		**City, Postal Code**	
Email Address		**Phone (Home)**	
Phone (Work)		**Phone (Cell)**	

Please Note: An incomplete referral will not be processed, and the patient will NOT be wait-listed

AREA OF PAIN FOR TREATMENT



Pain Description:

1. **Is the patient referred for Group Medical Visit only?** *(No diagnostics needed)*
☐ **Yes** ☐ **No**

2. **Reason for Referral** *(Please provide sufficient information for triage)*

3. **What treatments have been tried already?** ** Required*

4. **If an Active 3rd Party patient, please mark below.**
☐ **WCB** ☐ **ICBC** ☐ **VAC** ☐ **Other**
Claim #

5. **Is any legal action pending related to the pain problem?**
☐ **Yes** ☐ **No**

Please answer ALL the following questions	**Y**	**N**	3. Does the patient have untreated/ongoing substance abuse disorder/addiction?	☐	☐
1. Is the patient scheduled for surgery related to the pain problem?	☐	☐	4.Is this patient able to participate in a graded light to moderate exercise program? If No, please clarify individual restrictions below:	☐	☐
2. Does the patient have poorly controlled psychopathology* (psychosis, suicidal etc.)? *See exclusion criteria on Page 2.	☐	☐	5. Is the patient aware of and agreeable to this referral and willing to undergo interventional treatment if applicable?	☐	☐

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PROGRAM DESCRIPTION:

- Our team of pain specialized medical and allied health professionals provides an Inter-Disciplinary Pain Management Program for patients requiring treatment of persistent pain
- As our services include MSP, extended health, and private pay, it is **Mandatory** for all patients to participate in an introductory program orientation session to understand the scope of services available to them.
- All eligible BC patients have access to our MSP services. Some medical procedures and allied health services are ONLY covered by private pay or third-party insurer.
- After the initial consult, recommendations may include any of the following: online individual follow-ups, online group medical visits, in-clinic procedures, or in-clinic allied health services. Note: In-clinic appointments are mainly pain procedures, allied health services.
- Patients co-create their 12 month program depending on what resources are accessible to them.To learn more, visit: www.changepain.ca

Criteria for Urgent Referral: *(please check all applicable)*

- ☐ Medically stable Cancer patients requiring urgent procedures
- ☐ Urgent multidisciplinary team assessment (private pay only)
- ☐ Patients with < 3 months onset radicular pain (radiologically plus clinically abnormal findings)
- ☐ Complex regional pain syndrome or Reflex Sympathetic Dystrophy (RSD)
- ☐ Non-responsive Depression (ketamine infusion)
- ☐ Severe neuropathic pain (lidocaine or ketamine infusion therapy)

INCLUSION CRITERIA *(please check all applicable)*

- ☐ Patient must have a family physician or a regular walk-in clinic that will provide follow up care and medication renewal.
- ☐ Patient is unresponsive to conventional treatment.
- ☐ Patient and/or caregiver are cognitively capable and willing to participate with suggested regimen oftherapy.
- ☐ Patient is able to communicate in English or able to bring an interpreter to all the appointments
- ☐ Patient requires perioperative optimization (SPOC)
- ☐ Referring Physician(s) agrees:
  - ☐ to participate with suggested regimen of therapy
  - ☐ to continue to be their primary care provider. **CHANGEpain does not take over primary care of the patient or ongoing medication prescriptions**
  - ☐ To order appropriate initial investigations ruling out red flag conditions
  - ☐ To send completed results

EXCLUSION CRITERIA

Please note any patient with these conditions will sent back to the referring clinician for care.

- Patient is medically unstable requiring inpatient care and monitoring.
- Patient has an undertreated ongoing infection source.
- Patient has untreated/uncontrolled addiction to controlled substances or mental illness, leaving them unable to comply with pain management recommendations.

Please inform patients NOT to call the clinic.

We will contact them when they have been approved through the referral process.

Thank you for sharing the accurate and timely information as this expedites the referral process!

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