75 Poseidon Bay
Winnipeg, MB R3M 3E4
Phone 204 927-2609
Fax 204 927-2673

MS261 – 820 Sherbrook St
Winnipeg, MB R3A 1R9
Phone 204 787-3018
Fax 204 787-3127

PAIN MANAGEMENT REFERRAL FORM

Patient Name (please print clearly): _____
Surname Given Name Middle

Date of Referral: _____ yyyy/mmm/dd DOB: _____

Address: _____

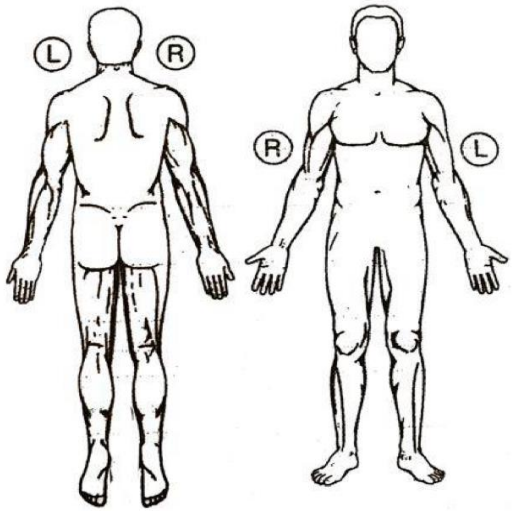
MHSC:_____ PHIN:_____ Daytime Phone:_____ Cell Phone:_____

Referring Physician (please print name):_____ Phone:_____ Fax:_____

Referring Physician Signature: _____

Primary Care Physician: _____ Phone:_____ Fax:_____

AREA OF PAIN FOR TREATMENT



1. Reason for Referral _____
_____
_____
_____

2. Treatments tried:_____
_____
_____

3. Duration of pain:_____

PLEASE ANSWER ALL THE QUESTIONS Referral may be returned if inadequate information provided	**Y**	**N**		**Y**	**N**
1. Is the patient scheduled for surgery related to the pain problem?			7. Is the pain related to an active Manitoba Public Insurance, Worker's Compensation Board, Department of National Defense or other 3rd Party Claim?		
2. Does the patient have poorly controlled psychopathology (psychosis, suicidal etc)?			8. If YES, Claim Number_____		
3. Does the patient have untreated/ongoing substance abuse/addiction?			9. Is there any legal action related to the pain problem?		
4. Does the patient have a significant needle fear (fainting, panic attacks etc)?			10. Have appropriate diagnostic tests been done? (See Diagnostic Tests on page 2.) **PLEASE ATTACH RESULTS.**		
5. Is the patient willing to have interventional (injection) treatments?			11. Does the patient have a significant communicable disease (MRSA, VRE, ESBL, Hepatitis, HIV, TB, etc)?		
6. Is the patient aware and agreeable to this referral?			12. Has the patient been reviewed by another pain specialist in the past? If so, where? _____		

Place Label Here

DIAGNOSTIC TESTS (to be completed prior to referral):

1. All patients referred with spinal pain: results less than 1 year
   - CT or MRI of appropriate area
2. All patients referred for chronic headaches: results less than 2 years
   - Neurology Consult by Neurologist
   - CT cervical spine
3. Patients being considered for Complex Regional Pain Syndrome (CRPS) diagnosis and treatment
   - Recent x-ray confirming no fracture to the affected limb
   - Please note and document any changes to color, hair, nails, sensation or swelling to the affected area

PLEASE ATTACH:

1. Complete medication list including any anticoagulants
   - Please include reason for anticoagulant therapy
2. ALL pertinent scans (CT, MRI, X-ray, bone scans, US, NCS)
3. ALL pertinent consults from other physicians including surgical reports

PAIN MANAGEMENT CLINIC:

- This is a Multi-disciplinary Pain Management Clinic for people requiring treatment of severe chronic pain, unresponsive to conventional treatment
- All patients will be invited to participate in Pain Education Classes
- Disciplines specific to pain management include: Psychology, Physiotherapy, Nursing, Pain Specialist/Anesthesia, Clinical Pharmacy, and Physical Medicine Rehabilitation
- Consults/visits can include individualized appointments and/or group sessions

INCLUSION GUIDELINES:	**EXCLUSION GUIDELINES:**
▪ Patient is unresponsive to conventional treatment ▪ ALL appropriate initial investigations are complete ▪ Physician(s) agree to participate with suggested regimen of therapy ▪ Patient/Caregiver cognitively capable/willing to participate in suggested regimen of therapy	▪ Has orthopedic condition and awaiting surgical intervention ▪ Is hemodynamically unstable or has medical condition requiring inpatient care and monitoring ▪ Ongoing infection source without appropriate antimicrobial therapy ▪ Infection constituting significant hazard to other patients and staff ▪ Untreated addiction to controlled substances ▪ Untreated mental illness ▪ Medical Marijuana is currently **NOT** prescribed by the Pain Management Clinic

An incomplete referral may not be processed and will be returned by fax.

Thank you, Pain Management Clinic