McMaster University Medical Centre
4th Floor Yellow Section 4V
1200 Main St. West, Hamilton, ON L8N 3Z5
Phone: (905) 521-2100, Ext. 44621
Fax: 905-577-8022 Website: www.hhsc.ca/pain

Please note that all referrals must be completed on this form.

Please provide as much detail as possible to ensure your patient is triaged appropriately.

PATIENT INFORMATION

Please affix a Patient Information label here (or complete information below)

Surname: Frist Name:

Address:

Male or Female: DOB:

Health Card Number:

Home Phone:

Cell Phone:

Email Address:

Preferred method of Contact:

☐ Phone ☐ Text ☐ Email ☐ Letter

Consent to Contact using preferred method: ☐

PHYSICIAN INFORMATION:

Referring Physician:	Telephone #:	Fax #:
Referring Physician Billing #:	Do you belong to a Family Health Team? Yes ☐ No ☐	
Family Physician (if different from above):	Telephone #:	Fax #:
Family Physician Billing #:	Number of years patient with Family Physician:	

TREATMENT OPTIONS? (Please check appropriate box):

OHIP FUNDED:

All new patients will have an Allied Health Assessment (to determine suitability for educational interdisciplinary groups)

☐ Assess the patient and suggest a treatment plan for me to follow

☐ Technical referral ex: Epidural, Stellate Block, Facet/SI Joint Injections

☐ Other _____

THIRD PARTY FUNDED: Patient must be able to converse in English, work in groups, be cooperative, and be independent in self-care i.e. personal care, etc.

☐ Interdisciplinary Assessment (to determine suitability for cognitive/behavioural interdisciplinary group program)

The patient is seen by a pain physician, psychologist, and an allied health professional

☐ Other _____

THIRD PARTY FUNDING AGENCY INFORMATION

☐ WSIB - Claim # _____ ☐ Department of National Defense - M# _____

☐ Motor Vehicle Accident - Claim # _____ ☐ Employer _____

☐ Veteran Affairs - K# _____ ☐ Other _____

When we receive the referral we will assist your patient with the funding approval. If you have any questions regarding funding please contact **Sonya Altena at 905-521-2100, Ext. 74342 or by email altena@hhsc.ca**

CLINICAL INFORMATION

Pain Diagnosis if available:

Duration of Pain Problem: **(Please check appropriate box)**

☐ Less than 3 months ☐ 3 - 6 months ☐ More than 6 months

Please check appropriate box

Urgent

- ☐ Cancer
- ☐ Complex Regional Pain Syndrome (CRPS) < 6 months
- ☐ Neuropathic Pain
- ☐ Back Pain < 6 months
- ☐ Lumbar Radicular Pain < 6 months
- ☐ Cervical Radicular Pain < 6 Months

Non Urgent

- ☐ Headache
- ☐ Complex Regional Pain Syndrome (CRPS) > 6 months
- ☐ Neuropathic Pain
- ☐ Back Pain > 6 months
- ☐ Lumbar Radicular Pain
- ☐ Neck Pain
- ☐ Cervical Radicular Pain
- ☐ Abdominal Pain
- ☐ Other: _____

MEDICAL HISTORY

Attach all listed reports to referral

- ☐ Legible history of pain problem
- ☐ Medical history including allergies, Height _____ Weight _____ BMI _____
- ☐ Current medications and dosages
- ☐ Previous medications tried for pain relief

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

☐ MRI ☐ CT ☐ EMG ☐ Ultrasound ☐ Other _____

Do they have significant depression and/or anxiety? YES ☐ NO ☐ If yes, treatment reports attached? ☐

Any history of Drug/Alcohol abuse or addiction? YES ☐ NO ☐ If yes, treatment reports attached? ☐

Please have the patient complete the following screening tools (available on website) and attach to referral.

☐ Brief Pain Inventory ☐ S-LANSS ☐ PHQ-4 ☐ PCS ☐ TSK ☐ PSEQ

PREVIOUS PAIN RELATED ASSESSMENTS / TREATMENTS: (please include reports)

- ☐ Psychologist
- ☐ Allied Health Professional (Social worker, Physiotherapist, Chiropractor etc.)
- ☐ Has this patient been evaluated by another pain specialist/ or receiving treatment at another pain clinic?
- ☐ Independent Medical Evaluation IME

Consultants at the Michael G. DeGroote Pain Clinic practice on a shared care model. One of our admission criteria is that Family Physicians play an active role in the treatment of their patients. We will provide assessment and a treatment plan for your patients chronic pain problem. In some cases the treatment may be initiated by our clinic, however, once stabilized the patient will be returned to you for ongoing care. This includes ongoing Pharmacotherapy, that may include opioids. If in agreement, please sign this form.

_____ _____

Family Physician Date

Are you willing to prescribe opioids for this patient if recommended? YES ☐ NO ☐ If No please provide reason:

_____

If you require further information please contact: Sandra MacDuff RN, BScN, P: 905-521-2100 ext. 75863