Hamilton Health Sciences

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

Michael G. DeGroote PAIN CLINIC

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: First 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 **905-521-2100, Ext. 44621 or by email** pain@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	**Non Urgent**
☐ Cancer	☐ Headache
☐ Complex Regional Pain Syndrome (CRPS) < 6 months	☐ Complex Regional Pain Syndrome (CRPS) > 6 months
☐ Neuropathic Pain	☐ Neuropathic Pain
☐ Back Pain < 6 months	☐ Back Pain > 6 months
☐ Lumbar Radicular Pain < 6 months	☐ Lumbar Radicular Pain
☐ Cervical Radicular Pain < 6 Months	☐ 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: our Charge Nurse, P: 905-521-2100 ext. 42590

BRIEF PAIN INVENTORY

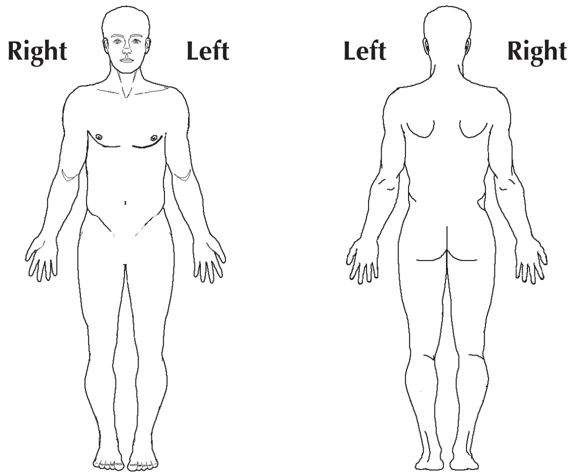
Date ______ /______ /______ Time:___________

Name:________________ ________________ __________
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10

No Pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

____

____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%

No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10

Does not interfere — Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology, The University of Texas MD Anderson Cancer Center. Used with permission. Adapted to single page format.

Provided as an educational service by ENDO PHARMACEUTICALS

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

____

____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

____

____

Do you have any other symptoms? Circle any that apply:

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call your doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

____

____

____

____

____

____

Provided as an educational service by ENDO PHARMACEUTICALS

PM-0033R/September, 2004

THE S-LANSS PAIN SCORE

1. **In the area where you have pain, do you also have "pins and needles", tingling or prickling sensations?**
   a) NO- I don't get these sensations (0)
   b) YES- I get these sensations (5)

2. **Does the painful area change colour (perhaps look mottled or more red) when the pain is particularly bad?**
   a) NO- The pain does not affect the colour of my skin (0)
   b) YES-I have noticed that the pain does make my skin look different from normal. (5)

3. **Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.**
   a) NO- The pain does not make my skin abnormally sensitive to touch. (0)
   b) YES- My skin in that area is particularly sensitive to touch. (3)

4. **Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like "electric shocks", jumping and bursting might describe this.**
   a) NO- My pain doesn't really feel like this. (0)
   b) YES- I get these sensations often. (2)

5. **In the area where you have pain, does your skin feel unusually hot like a burning pain?**
   a) NO- I don't have burning pain (0)
   b) YES- I get burning pain often (1)

6. **Gently <u>rub</u> the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area?**
   a) The painful area feels no different from the non-painful area (0)
   b) I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area. (5)

7. **Gently <u>press</u> on the painful area with your finger tip and then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?**
   a) The painful area does not feel different from the non-painful area. (0)
   b) I feel numbness or tenderness in the painful area that is different from the non-painful area. (3)

Scoring a score of 12 or more suggests pain of predominantly neuropathic origin

Source: Bennett, M et al The journal of Pain, Vol 6, No 3 March, 2005 pp 1490158 The S-LANSS Score for Identifying Pain of Predominantly Neuropathic Origin: Validation for Use in clinical and Postal Research The Journal

PHQ-4				
Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute

TSK

Client No.:____________ Age: ______ Sex: M(__) F(__) Date:______

Instructions Please read each of the following statements and circle the number that better represents your feelings		Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
1.	I'm afraid that I might injure myself if I exercise ……………...	1	2	3	4
2.	If I were to try to overcome it, my pain would increase ………..	1	2	3	4
3.	My body is telling me I have something dangerously wrong …..	1	2	3	4
4.	People aren't taking my medical condition seriously enough ….	1	2	3	4
5.	My accident has put my body at risk for the rest of my life ……	1	2	3	4
6.	Pain always means I have injured my body ……………………	1	2	3	4
7.	Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening …………………………………………………….....	1	2	3	4
8.	I wouldn't have this much pain if there weren't something potentially dangerous going on in my body ……………………	1	2	3	4
9.	Pain lets me know when to stop exercising so that I don't injure myself ………………………………………………………..	1	2	3	4
10.	I can't do all the things normal people do because it's too easy for me to get injured ………………………………..................	1	2	3	4
11.	No one should have to exercise when he/she is in pain ………...	1	2	3	4

Pain Catastrophizing Scale

Sullivan MJL, **Bishop** S, **Pivik** J. (1995)

Name:	**Age:**	**Gender:**	**Date:**
------------------------------	----------	☐Male ☐Female	----------------------

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

<u>Instructions</u>:
We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	**0**	**1**	**2**	**3**	**4**
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I'm in pain …

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events	
8	I anxiously want the pain to go away	
9	I can't seem to keep it our of my mind	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop	
12	There's nothing I can do to reduce the intensity of the pain	
13	I wonder whether something serious may happen.	

Copyright 1995 Michael J.L. Sullivan. Reproduced with permission.
Source: **Sullivan** MJL, **Bishop** S, **Pivik** J. The **pain catastrophizing scale**: development and validation. *Psychol Assess*, **1995**, 7: 524-532

PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)

M.K.Nicholas (1989)

NAME: ____ DATE: _________________

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle **one** of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Remember, this questionnaire is **not** asking whether of not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

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1. I can enjoy things, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

2. I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

3. I can socialise with my friends or family members as often as I used to do, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

4. I can cope with my pain in most situations.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Turn over

5. I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work).

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

6. I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

7. I can cope with my pain without medication.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

8. I can still accomplish most of my goals in life, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

9. I can live a normal lifestyle, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

10. I can gradually become more active, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Source: Nicholas M.K. Self-efficacy and chronic pain. Paper presented at the annual conference of the British Psychological Society. St. Andrews, 1989.
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