EXTERNAL REFERRAL FORM

For quick access to pain services, please consider the following:

- Referral to a pain specialist via https://econsultontario.ca to have pain related questions answered within days by a pain specialist.
- Referral to free pain resources, courses, and peer support via https://poweroverpain.ca
- Determine if your patient has coverage for private health benefits for rehabilitation therapies (e.g., physiotherapy, occupational therapy, psychotherapy) to help cope with their chronic pain problem.

Please review the following:

Patients referred to the Michael G. DeGroote (MGD) Pain Clinic must have a Primary Care Provider (PCP), who is **expected to play an active role in the treatment of their patient**. When completing this referral, please include **all information in the form where indicated**. Missing information will result in triaging and booking delays for your patient.

Referrals will be reviewed and if accepted your patient may receive a medical consultation from a physician/nurse practitioner as well as consultation from other healthcare providers in our interprofessional team.

Initial beside each statement, if in agreement:

_____ I understand that MGD physicians and nurse practitioners will **NOT** take over prescribing of **controlled and/or non-controlled substances** for my patient.

_____ I understand that in cases where a **controlled and/or non-controlled substance** is initiated by the MGD Pain Clinic, once stabilized (6-24 months) the patient will be returned to the PCP for ongoing care, **including pharmacotherapy prescribing, with our continued support.**

If not in agreement, please provide rationale:

Referrer Name: **Patient Name:** **Date:**

Referrer Signature:

REFERRAL INCOMPLETE WITHOUT SIGNATURE

Michael G. DeGroote Pain Clinic - 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

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION A - REFERRING PROVIDER INFORMATION

REFERRING PROVIDER:

EMAIL:

ADDRESS:

PHONE:

FAX:

DO YOU BELONG TO A FAMILY HEALTH TEAM? ☐ Yes

PRIMARY CARE PROVIDER (PCP) INFORMATION (IF DIFFERENT THAN ABOVE)

PCP NAME:

PCP LICENSE#:

PCP PHONE:

PCP FAX:

SECTION B - REFERRAL INFORMATION

☐ NEW REFERRAL

☐ RE-REFERRAL (must provide reason below):

TREATMENT SOUGHT

☐ INTERVENTION (If yes, go to **section G on page 5**)

☐ MEDICATION CONSULTATION

☐ GROUP EDUCATION (If yes - is the patient medically cleared to participate in exercise? ☐ Yes

WHEN DID THE PAIN START?: ☐ Less than 3 months ago ☐ 3-6 months ago ☐ More than 6 months ago

DOES THE PATIENT HAVE ACTIVE CANCER OR ARE THEY DEEMED PALLIATIVE? ☐ Yes

DOES THE PATIENT HAVE ANY OF THE FOLLOWING PAIN CONDITIONS?:

☐ CRPS ☐ Back Pain ☐ Lumbar Radicular Pain ☐ Cervical Neck Pain

IS THE PATIENT A CANADIAN ARMED FORCES VETERAN?: ☐ Yes

HAS THE PATIENT HAD A WORKPLACE INJURY OR MOTOR VEHICLE ACCIDENT (MVA) IN THE PAST 5 YEARS?: ☐ Yes

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION C - PATIENT DEMOGRAPHICS

FIRST NAME:		MIDDLE NAME:	
SURNAME:		PREFERRED NAME:	
OHIP #:		VERSION:	DOB (DD/MM/YYYY):
SEX:		GENDER:	PRONOUNS:
STREET ADDRESS:			
CITY:		PROVINCE: ON	POSTAL CODE:
HOME PHONE:	CELL PHONE:	EMAIL:	HEIGHT: / WEIGHT:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER: ☐ INTERPRETER REQUIRED?

☐ VISUAL IMPAIRMENT ☐ HEARING IMPAIRMENT ☐ MOBILITY/FALL RISK ☐ COGNITIVE IMPAIRMENT

SECTION D - CURRENT AND PAST TREATMENTS

CONSERVATIVE

☐ Acupuncture ☐ Chiropractic ☐ Dietitian ☐ Occupational Therapy ☐ Physiotherapy

☐ Psychology ☐ Social Work ☐ Naturopath/Homeopath/Osteopath

INTERVENTIONAL

☐ Epidural ☐ Intra-articular Injections ☐ Infusions ☐ Nerve Blocks ☐ Surgery

☐ Other (please specify):

MEDICATION (***Please complete or fax list – if no information provided, referral will be returned***)

	Current	Past	Not tried	Unknown	Response/Adverse Effects
gabapentin (Neurontin) / pregabalin (Lyrica)	☐	☐	☐	☐	
duloxetine (Cymbalta)	☐	☐	☐	☐	
amitriptyline (Elavil) / other TCA	☐	☐	☐	☐	
NSAIDs	☐	☐	☐	☐	
Opioids	☐	☐	☐	☐	
Cannabis / nabilone (Cesamet)	☐	☐	☐	☐	

Other (Please specify):

EXTERNAL REFERRAL FORM

PATIENT:

Michael G. DeGroote PAIN CLINIC

Hamilton Health Sciences

SECTION E - PAIN INFORMATION (SELECT ALL THAT APPLY)

☐ **Abdominal Pain**

☐ Chronic Pancreatitis ☐ Functional Abdominal ☐ Inflammatory Bowel Disease

☐ Post Surgical ☐ Irritable Bowel Syndrome ☐ Other:

GI specialist consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Headache (Please go to Section G to request specific intervention)**

☐ Acquired Brain Injury ☐ Cervicogenic Headache ☐ Occipital Neuralgia

☐ Migraine, Cluster, or Tension Headache ☐ Other:

Neurology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

Head/neck MRI or CT in past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Musculoskeletal Pain (Please go to Section G to request specific intervention)**

☐ Neck Pain - **Cervical MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Upper/Mid Back Pain - **Thoracic MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Low Back Pain - **Lumbosacral MRI** in the past 2 years?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ Joint/Limb pain - Indicate Joint(s) or Limb(s):

☐ **Neuropathic Pain (Please go to Section G to request specific intervention)**

☐ Complex Regional Pain Syndrome ☐ Multiple Sclerosis ☐ Painful Diabetic Neuropathy

☐ Phantom Limb Pain ☐ Post Stroke Pain ☐ Post Herpetic Neuralgia

☐ Trigeminal Neuralgia ☐ Post Surgical /Post Traumatic (Specify location below):

☐ Other:

Neurology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

EMG testing?. ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Pelvic Pain**

☐ Chronic Pelvic Pain ☐ Endometriosis ☐ Interstitial Cystitis ☐ Post-Surgical/-Traumatic

☐ Other:

BGYN or Urology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

☐ **Rheumatological Pain**

☐ Fibromyalgia ☐ Lupus ☐ Polymyalgia Rheumatica ☐ Rheumatoid Arthritis

☐ Sjogren's Syndrome ☐ Other:

Rheumatology consultation?: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **Unknown**

EXTERNAL REFERRAL FORM

PATIENT:

SECTION F - PSYCHIATRIC DIAGNOSES

- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Insomnia
- ☐ ADHD
- ☐ Psychosis/Schizophrenia
- ☐ Eating Disorder
- ☐ Autism Spectrum Disorder
- ☐ Substance Use Disorder (specify):
  - ☐ Alcohol
  - ☐ Opioids
  - ☐ Cannabis
  - ☐ Other:

SECTION G - REQUEST FOR SPECIFIC INTERVENTIONAL TREATMENT

Head and Neck Pain

Please select all that apply: ☐ Head Dominant ☐ Limb Dominant ☐ Facial Dominant ☐ Neck Dominant ☐ Whiplash Associated Disorder

Radicular features? ☐ Yes ☐ No ☐ Unknown

Specific request for **head/neck** intervention:

Low Back Pain

Please select all that apply: ☐ Back Dominant ☐ Limb dominant ☐ Non-Mechanical back pain ☐ SI Joint Dominant ☐ Failed back surgery syndrome

Radicular features? ☐ Yes ☐ No ☐ Unknown

Specific request for **head/neck** intervention:

Other region/limb/joint pain, please specify intervention:

SECTION H – SUPPLEMENTAL FORMS AND DOCUMENTS – PLEASE ATTACH

Submit the following imaging relevant to pain problem: ☐ **Ultrasound** ☐ **CT** ☐ **ED CHART** ☐ **MRI** ☐ **EMG**

Please have your patient complete the following measures and fax back with referral form:

☐ **painDETECT**	☐ **Pain Disability Index**	☐ **PHQ-4**	☐ **PCS**	☐ **TSK**	☐ **PSEQ**