Alberta Health Services | Covenant Health | LifeMark Health Institute

Adult Chronic Pain Specialist Referral

Please print clearly

Place Patient Label Here

Mandatory Data Required for Processing Referral *(Missing or incomplete information will delay processing)*

- Client name and demographics
- Family physician name
- Reason for referral

Client Demographics

Name *(last)* _____ *(first)* _____

Street address _____ City _____ Postal Code _____

Home phone _____ Alternate phone _____

PHN _____ Gender ☐ M ☐ F Date of birth *(d / m / y)* _____

Referring Source (*Medical Doctor only)*

Name _____

Phone _____

Fax _____

PRACID # _____

Family Physician (*If different than referring source)*

Name _____

Phone _____

Fax _____

Is this an active WCB patient? ☐ Yes ☐ No

Attach pertinent consultation and imaging reports that are NOT available on netCARE

(e.g., previous pain programming, relevant specialist consultations, x-ray, MRI, etc.)

Please indicate which statement best describes this patient:

☐ **Emerging pain condition** — relatively uncomplicated medication profile; limited impairment and duration, but single treatment/therapies have been ineffective. Patient would benefit from an assessment, education, and possibly specialized treatment.

☐ **Debilitating and complex pain** — and/or significant behavioural/emotional involvement; a complex medication profile and/or an addiction. Patient likely requires highly specialized medical intervention and/or multidisciplinary programming.

History of Present Condition *Patient currently displays the following due to pain:*

☐ Decreased physical conditioning
☐ Decreased ability to complete ADLs
☐ Disability that exceeds clinical findings
☐ Disrupted sleep
☐ Increased medical/health services utilization
☐ Medication tolerance and/or mismanagement
☐ Significant activity restriction/reduced vocational abilities
☐ Significant mood disturbance e.g. anxiety, depression

What are the patient's key issues at present? _____

Diagnoses and Syndromes *Mark (✓) all diagnoses/syndromes that apply and* ***circle*** ***the most disabling at present***

- ☐ Low Back Pain with radiculopathy
- ☐ Low Back Pain without radiculopathy
- ☐ Herpetic Neuralgia
- ☐ Temporomandibular joint dysfunction/pain
- ☐ Spondyloarthropathies (i.e. ankylosing spondylitis)
- ☐ Myofascial pain syndrome
- ☐ Peripheral neuropathy
- ☐ Fibromyalgia
- ☐ Emerging Complex Regional Pain Syndrome
- ☐ Established Complex Regional Pain Syndrome
- ☐ Arthritis (osteoarthritis, rheumatoid arthritis)
- ☐ Headache
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Unknown
- ☐ Other _____

How long has this patient been in pain? ☐ less than 3 months ☐ 3 to 6 months ☐ 6 to 12 months ☐ more than 1 year

Past Treatment History

What treatment strategies have been attempted for the most disabling diagnosis circled above?

- ☐ Single modality rehabilitation (OT, PT, chiropractic)
- ☐ Multidisciplinary rehabilitation
- ☐ Counseling
- ☐ Anticonvulsants
- ☐ NSAID's
- ☐ TCA's
- ☐ Opioids
- ☐ Epidurals
- ☐ Sympathetic blocks
- ☐ Somatic nerve blocks
- ☐ Trigger point injections
- ☐ Alternative treatments _____
- ☐ Surgery _____
- ☐ Other _____

Reason for Referral _____

_____

Preferred Pain Specialist ☐ None ☐ Dr. _____

Note: Indicating a preference may impact your patient's wait time.

Has your patient previously been assessed and/or treated at a chronic pain facility in Edmonton?

☐ Yes ☐ No *(If Yes, please specify location and dates)* _____

Special Requirements

☐ Hearing, visual impairment requires oxygen, etc.

Please specify _____

☐ Cognitive impairment.

Please describe _____

☐ Unable to read or speak English. *Please specify language* _____

Translator/contact person _____ Phone number _____

Please fax completed form to Alberta Health Services Central Access – Edmonton Zone

Fax: 780-735-3553 Toll Free Fax: 1-866-979-3553 Phone: 780-401-2665