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Community Pain Management Program
Referral Form: Opioid Use Disorder/Chronic Pain Program
Primary Care and Health Care Provider

Referral Form: Please choose one Community Pain Clinic site

☐ Fraser North (Tri-cities) ☐ Fraser South (Surrey) ☐ Fraser East (Chilliwack) **Date:** _____

*** Please complete all information below**

Patient Information:

Name: _____ DOB:_____ PHN:_____

(dd/mm/yyyy)

Daytime Phone: _____ Cell phone:_____ Email:_____

Address: _____ (educational material only)

_____ (include postal code)

Referring Health Care Provider

☐ GP ☐ Nurse Practitioner ☐ Specialist ☐ Other

Name:_____ MSP #_____ Phone:_____

FAX:_____

Primary Care Provider ☐ as above **OR**

Name:_____ MSP #_____ Phone:_____ FAX:_____

Pain Clinic Criteria for Service

☐ The patient is aware:

- This is an Interdisciplinary Pain Program for patients with Opioid Use Disorder (OUD), history of OUD or at risk for OUD.

Referrals for patients with other Substance Use Disorders will also be considered if space permits

- The patient consents to the Pain Clinic contacting their Primary Care provider (PCP) & other Health Care Providers as needed to support care
- Untreated addictions: Patient consents to MHSU program connection/referral prior or during Pain Clinic program if needed
- Patient lives within the catchment area of Fraser Health

1. Is this patient able to participate in light-moderate exercise program? ☐ Yes ☐ No
2. Active 3rd Party Patient? ☐ Yes ☐ No
   ☐ WCB ☐ ICBC ☐ Other_____
   Claim #_____

- The Community Pain Management Program is an Interdisciplinary Clinic with a 8 week group/educational/self-management program
- Team includes PT,OT, Nurses & access to Pain Specialist, SW, Pharmacist & MHSU services
- Patients will be triaged according to predetermined criteria and seen by the appropriate provider(s) in addition to group and self-management sessions.

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Duration of Pain ☐ 3-12 months ☐ 1-3 years ☐ Greater than 3 years

Location, condition or type of Pain(s)

Medical History ☐ Attached
☐ Brief relevant summary below

Substance Use History
☐ Attached ☐ Brief relevant history below
☐ Currently within MHSU program ☐ Opioid Antagonist Therapy (OAT) ☐ Other_____
☐ Addiction Medicine management Specialist Name:_____
Phone:_____
☐ Primary Care Provider management
☐ Other _____
Goals of current management:_____

Mental Health
☐ None identified ☐ Attached
☐ Anxiety ☐ Depression ☐ Post –Traumatic Stress Syndrome
☐ other Psychiatric Disorder _____
☐ Followed by Mental Health Team Name: _____
Phone:_____
☐ Brief relevant summary below

Previous Pain Care/Treatment
☐ Unknown
☐ Brief summary below include any medications trials, Health Care Providers seen, treatment and interventional procedures

Include the following:

- Brief Pain Inventory (BPI) – please complete the attached form or provide a recent office copy from the past two months
- Medical History (include current medications & allergies)

☐ Pertinent scans and Imaging ☐ Pertinent consults from other physicians

- **FAX to : 604-582-4591: attention Clinical Coordinator Community Pain Clinics**

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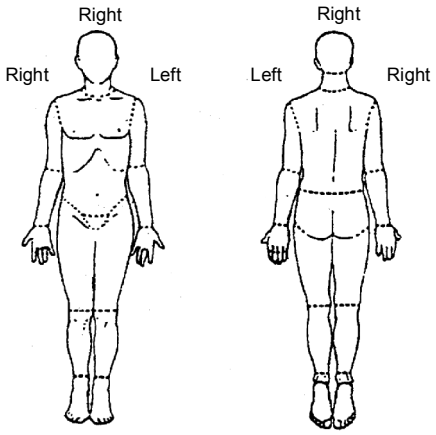
BPI (SHORT FORM)
PAIN CLINIC

Date: _____

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

Date: _____

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 most 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										Pain as bad as you can imagine

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