Chronic Pain Services
REFERRAL FORM

Date referred (YYYY−MM−DD): _____ Fax Number: 902−473−4126

Referral will be triaged to urgency level and provincial location. Patient will be contacted with next available appointment.

The NSHA Chronic Pain Services will not take over prescribing permanently. Once stabilized on treatment the patient will be transferred back to their primary care provider for continuing care including pharmacotherapy.

✓ please ensure that appropriate investigations have been completed

✓ **do not attach** test results completed within the Nova Scotia Health Authority. **Do include** reports from private clinics.

Urgency Level: *indicate your assessment of **urgency level** by completing one of the boxes below*

❑ **Level 1** − Urgent referral
Patient is palliative with less than 6 months life expectancy. Requesting urgent anesthesia assessment for block procedure or other treatment.

❑ **Level 2** − Fast track referral
- ❑ Acute disc and sciatica (onset less than 6 months)
- ❑ Complex regional pain syndrome (onset less than 6 months)
- ❑ Post Herpetic Neuralgia (onset less than 6 months)
- ❑ Post−surgical neuroma (onset less than 6 months)

❑ **Level 3** − Regular referral. *Check the treatment stream below that best meets the patient's needs.*

❑ **STREAM I** *(wait−time is shorter than STREAM II)*
Pain Self−Management group Program
- allied health team provide education and strategies to help with pain relief and quality of life.
- **patient will commit to** regular attendance, active participation & willingness to implement new strategies

❑ **STREAM II**
Physician assessment
Pharmacotherapy
Interventional treatment
Recommendations for Stream I as needed

Previous Treatment: *indicate the treatment(s) trialed at the primary care level and/or other clinics*

Pharmacotherapy: ❑ anticonvulsants ❑ antidepressants ❑ opioids ❑ cannabinoids ❑ acetaminophen ❑ NSAIDs

❑ Psychology ❑ Physiotherapy ❑ Pain self−management program ❑ Block procedure/injection. type _____

❑ Previously seen by another pain specialist/clinic. Please specify _____

❑ Other _____

Description of Pain: *help us understand* **THE REASON FOR THIS REFERRAL** *by completing the section below*

Brief history of pain. Please specify the primary site of pain and onset:

_____

_____

_____

Specific clinical question/request:

_____

_____

Referring Practitioner: *referrals will be returned if form is incomplete*

Name (print clearly): _____ Signature: _____ Direct Phone Number: _____

Name of Primary Care Provider if different from referring practitioner: _____