UNIVERSITY OF SASKATCHEWAN
Chronic Pain Clinic
COLLEGE OF PHARMACY AND NUTRITION

Health Sciences Building
University of Saskatchewan
E1300, 104 Clinic Place, Saskatoon, SK
P: 306-966-6469 | F: 306-966-6656
medicationassessmentcentre@usask.ca

Patient addressograph or
Name:
DOB:
HSN:
Address:
Contact Number:

HEALTH CARE PROVIDER REFERRAL FORM

The USask Chronic Pain Clinic (CPC) includes pharmacists, medical social workers, physical therapists, and a physician. We offer an interprofessional approach to chronic pain management which includes medication, mind, and movement strategies. We strive to support people living with chronic pain in collaboration with their primary care provider(s). Our support for individual clients is temporary, typically around 6-18 months.

If a client has a WCB or SGI claim/case currently open or they are currently a client with another pain clinic, they are not a candidate for the USask CPC. A referral may be made once the WCB or SGI claim/case is closed, or they are no longer a client of another pain clinic. Please contact us if you have further questions.

Referring Provider Printed Name:	
Phone:	**Referring Provider's role:**
Family Physician/Nurse Practitioner Name (if different from above):	
Phone:	**Fax:**

The USask CPC **does not** take over prescribing medications and **requires close, ongoing collaboration** with patient's primary care prescriber (family physician or nurse practitioner) to implement any medication changes.

In completing this referral:

☐ I, the referring family physician/nurse practitioner, agree to collaborate on an ongoing basis with the USask CPC team

OR

☐ I, the referring non-prescribing provider, agree to contact the patient's family physician or nurse practitioner (if applicable) to make them aware of this referral

Priority and Purpose of Referral (Check all that apply):

Urgent referrals will only be triaged as urgent if the referring provider is available to discuss the referral (by phone/Zoom) with the USask CPC Physician. Urgent referrals are only available for consultations related to chronic pain medications and/or mentorship for opioid agonist therapy prescribing.

Routine Referral

- ☐ Interprofessional team chronic pain management (medication, mind, and movement strategies)
  - Patient must be willing to participate with the interprofessional team. Once referral is processed an intake package will be sent to patient collect additional health information.
  - Patient agrees to participate with interprofessional team and provide intake package information as requested as evidenced by the patient's initials here _________________*(if referral is completed virtually primary care provider can initial indicating patient's verbal consent)*
- ☐ Pharmacotherapy consult for medication prescribing support
- ☐ Mentorship for opioid agonist therapy prescribing for chronic pain

Urgent Referral

- ☐ Pharmacotherapy consult for medication prescribing support
- ☐ Mentorship for opioid agonist therapy prescribing for chronic pain

Incomplete referrals may be returned
To be completed by a referring health care provider in discussion with patient.

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Please indicate the patient's currently known pain diagnoses below. Check all that apply.

Abdominal pain
- ☐ Crohn's/Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Other___________________________

Headache
- ☐ Cervicogenic headache
- ☐ Cluster headache
- ☐ Migraine tension-type headache
- ☐ Occipital neuralgia
- ☐ Temporomandibular joint disorder
- ☐ Medication overuse headache
- ☐ Other___________________________

Musculoskeletal pain
- ☐ Post-operative back pain
- ☐ Low back pain
  - ☐ Back dominant
  - ☐ Leg dominant
- ☐ Neck pain
  - ☐ Neck dominant
  - ☐ Arm dominant
- ☐ Sacro-iliac joint pain
- ☐ Whiplash-associated disorder
- ☐ Other___________________________

Opioid management/Substance use
- ☐ Aberrant drug-related behaviours
- ☐ Escalating opioid therapy
- ☐ Patient interested in tapering
- ☐ Substance Use Disorder (patient must have co-occurring CNCP)

Pelvic pain
- ☐ Endometriosis
- ☐ Interstitial cystitis
- ☐ Vulvodynia
- ☐ Other___________________________

Neuropathic Pain
- ☐ Complex Regional Pain Syndrome
- ☐ Multiple Sclerosis
- ☐ Painful diabetic neuropathy
- ☐ Phantom limb pain
- ☐ Post-stroke pain
- ☐ Post-traumatic pain
- ☐ Compression-related neuropathic pain
- ☐ Shingles and post-herpetic neuralgia
- ☐ Trigeminal neuralgia and atypical facial pain
- ☐ Other___________________________

Widespread pain disorders
- ☐ Fibromyalgia
- ☐ Myofascial pain syndromes
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Sickle cell disease
- ☐ Systemic exercise intolerance/chronic fatigue/Myalgic encephalomyelitis
- ☐ Other autoimmune condition __________________

Other
- ☐ Please specify

____
____
____

Does the patient have?
- ☐ Multiple areas of pain
- ☐ Single focus of pain
- ☐ Dermatomal distribution of pain

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Please provide additional information about the patient below. Check all that apply.

Social History

- ☐ Patient is on disability leave
- ☐ Patient is employed (Full-time___Part-time___)
- ☐ Patient has stable housing: Yes ____ No ____
- ☐ Patient receives Supplementary Health Benefits: Yes __ No ____

Functional Status (Activities of daily living)

- ☐ Good
- ☐ Managing
- ☐ Limited

Past CNCP interventions

- ☐ Physiotherapy
- ☐ Exercise therapy
- ☐ Pain education (e.g. Live Well)
- ☐ Pain clinic (e.g. Regina CPC)
- ☐ Traditional Indigenous Services
- ☐ Psychological interventions (e.g., CBT, ACT, DBT)
- ☐ Injections (e.g., steroids, hyaluronic acid)
- ☐ Other ___________________________________

The following documentation must be attached (as available)

- ☐ Random Urine Drug Screen for patients on controlled substances (**Required** - MS/MS test within the last 6 months)
- ☐ Musculoskeletal & neurological exam (must have been performed within the last 6 months)
- ☐ Medication List
- ☐ Health summary (e.g., brief medical history, chronic pain narrative)
- ☐ Specialist consultation notes relevant to pain management
- ☐ All relevant imaging

☐ **Does the patient have a mental health diagnosis which may be relevant when developing a chronic pain management care plan?** ☐ Yes ☐ No ☐ Unknown

If yes, please specify and attach as able any relevant consultation notes. _______________________________________

****

I have discussed this referral with the patient, and they consent to the referral as evidenced by their signature below and initials on page 1.

Referring Provider Signature: ____________________________ Date: ______________________________

By providing my signature I understand that use of my personal health information will be in line with *The Health Information Protection Act*, PART IV Limits on Collection, Use and Disclosure of Personal Health Information by Trustees. I understand and that my signature or verbal authorization to this release will allow the USask Chronic Pain Clinic to:

1.) Obtain any health record(s), including hospital records, physician/social worker/physical therapist office records, diagnostic imaging, pharmaceutical prescription records and patient billing information, or other information relevant to the program.

Patient Signature:____________________________________ Date:___________________________

(if referral is completed virtually primary care provider can initial indicating they have patient's verbal consent)

Patient Email: ____

Acknowledgement: *This USask Chronic Pain Clinic referral form was adapted from the Toronto Academic Pain Medicine Institute (TAPMI) and Regina Chronic Pain Clinic referral form.*

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