nova scotia health authority

Nova Scotia Chronic Pain Services

Referral Form

1	Date Referred:	Month: Day: Year:
	CLINIC BEING REFERRED TO	
2	Primary: ☐ Antigonish ☐ Berwick ☐ New Glasgow Secondary: ☐ Amherst ☐ Dartmouth ☐ Sydney ☐ Truro ☐ Windsor ☐ Yarmouth Tertiary: ☐ Halifax-IWK ☐ Halifax-QEII	
	PATIENT INFORMATION	
3	Health Card Number (HCN):	
4	Last Name:	
5	First Name:	
6	Date of Birth	Month: Day: Year:
7	Gender:	☐ Male ☐ Female ☐ Unknown
8	Address Street:	
	City:	
	Province:	
	Postal Code:	
9	Home Phone Number:	
10	Work (or Alternate) Phone Number:	
11	Is this a WCB Claim?	☐ Yes ☐ No ☐ Unknown
		If Yes, Claim Number:
	PARENT, GUARDIAN OR FAMILY MEMBER	
12	Name:	
13	Phone Number:	
	REFERRING PHYSICIAN	
14	Name:	
15	Area of Expertise:	☐ Family Doctor ☐ Dentist ☐ Neurology ☐ Internal Med ☐ Rehab Medicine ☐ Ortho ☐ Neuro surgery ☐ Anaesthesia ☐ Rheumatology ☐ Psychology/Psychotherapy
		If Other, Specify:
16	Direct Phone Number:	
17	Fax Number:	
	PAIN DESCRIPTIVES	
18	Primary Site of Pain:	☐ Head ☐ Aurofacial ☐ Abdomen ☐ Pelvis ☐ Neck ☐ Upper limb ☐ Upper back ☐ Genital ☐ Chest ☐ Lower limb ☐ Lower back ☐ Rectal/anal
		If Other, Specify:
19	Date of Onset of Pain:	Month: Day: Year:
20	Provisional Diagnosis:	

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BRIEF HISTORY

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CO-MORBID CONDITIONS (Check ALL that apply)

22

☐ Depression ☐ Anxiety Disorder ☐ Post Traumatic Stress
☐ Schizophrenia ☐ Bipolar Affective Disorder ☐ Addictions
☐ Other, please specify:

PREVIOUS TREATMENT (For current pain problem)

23 Pharmacology Treatments (check all that apply):

☐ None ☐ Anti-depressants ☐ Anticonvulsants
☐ NSAIDs/acetaminophen ☐ Opioids

Please list specific agents

24 Other Treatments (check all that apply):

☐ None ☐ Psychological Treatments ☐ Surgery for the pain
☐ Physiotherapy ☐ Acupuncture ☐ Exercise program

If Other, Specify:

PHYSICIAN'S ASSESSMENT OF TRIAGE LEVEL (Check the appropriate box)

25

Pain related to a diagnosis of cancer or other terminal illness	☐
Referral from a neurosurgeon or orthopedist for diagnostic block trial	☐
Acute disc herniation confirmed on imaging <6 months	☐
PHN (Post Herpetic Neuralgia) or post surgical neuroma <6 months	☐
CRPS (Complex Regional Pain Syndrome) – RSD (Reflex Sympathetic Dystrophy)	☐
Patients for joint assessment with neurosurgery for spinal cord stimulation	☐
All other referrals	☐

RELEVANT REPORTS

26 PLEASE ATTACH RELEVANT CONSULTANTS REPORTS AND INVESTIGATIONS SUCH AS REPORTS ON IMAGING, BLOOD WORK OR EMGS

SIGNATURE

27 In referring this patient, I agree to provide appropriate follow-up care for this patient's chronic pain condition once discharged from a Nova Scotia chronic pain clinic.

Signature:		Date:	Month	Day	Year