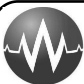
MonthConversion!



WOODSTOCK HOSPITAL
Woodstock, ON

INTERVENTIONAL PAIN REFERRAL FORM

Patient Information
Name: ____________________
Address: ____________________
City: __________ **Province:** _____ **Postal Code:** ______
Home phone: __________ **Cell phone:** __________
DOB: mmm dd yyyy ☐ **Male** ☐ **Female** ☐ **Other**
Health card number: ____________________

Physician Information
Referring Provider: ____________________
Billing number: ____________________
Phone number: ____________________
Fax number: ____________________
Copy to: ____________________
Fax copy: ____________________

☐ **WSIB** ☐ **3rd Party** ☐ **Self Pay**

Clinical History: ☐ **Routine** ☐ **Urgent**

Allergies: ☐ Xray/contrast dye ☐ Latex ☐ Other ______
Medications: ☐ Antibiotics ☐ Other
☐ Anticoagulation
Patient has been provided instructions to hold anticoagulation*? ☐ Yes ☐ No
☐ **Imaging attached by Referring Provider**

FOR REFERRER: Number of repeats/year ________

*****PAIN REFERRALS CAN NOT BE BOOKED UNLESS REFERRAL IS COMPLETED IN FULL*****

Spinal Procedures (will be completed with corticosteroid)

Procedure	Level / Side
Lumbar	
☐ Facet Joint Injection T	☐ L1–L2 ☐ R ☐ L
☐ Medial Branch Block T	☐ L2–L3 ☐ R ☐ L
☐ Radiofrequency Ablation (future service)	☐ L3–L4 ☐ R ☐ L
☐ Epidural Steroid Injection ** *(Interlaminar)*	☐ L4–L5 ☐ R ☐ L
	☐ L5–S1 ☐ R ☐ L
Lumbar	
☐ Selective Nerve Block ** / Transforaminal epidural injection ** *(will be selected based on clinical history and imaging provided)*	☐ L1 ☐ R ☐ L ☐ L2 ☐ R ☐ L ☐ L3 ☐ R ☐ L ☐ L4 ☐ R ☐ L ☐ L5 ☐ R ☐ L ☐ S1 ☐ R ☐ L
Sacrum	
☐ Sacroiliac Joint injection T ☐ R ☐ L	☐ Caudal epidural
☐ Coccyx Injection T	
Cervical	
☐ Facet Joint Injection T	☐ C3–C4 ☐ R ☐ L
☐ Medial Branch Block T	☐ C4–C5 ☐ R ☐ L
☐ Radiofrequency Ablation ** (future service)	☐ C5–C6 ☐ R ☐ L
☐ Epidural Steroid Injection ** *(Interlaminar)*	☐ C6–C7 ☐ R ☐ L
	☐ C7–T1 ☐ R ☐ L
Thoracic	
☐ Facet Injection T at __________	☐ Other (please specify) __________
☐ Epidural Steroid Injection ** *(Interlaminar)*	
☐ Intercostal Nerve Block T	

*T Requires relevant X-ray, CT, Bone scan within the last 2 years
** Requires relevant MRI spine within the last 2 years

Headache (must have a diagnosis of chronic migraine/occipital neuralgia)

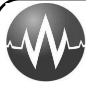
☐ 3rd Occipital Nerve Block
☐ Greater and Lesser Occipital Nerve Block
☐ Pericranial Nerve Blocks
☐ Botox for chronic migraine (non OHIP)

Peripheral Joint Procedures T (will be completed with corticosteroid)

Joint	Side
Shoulder	
Glenohumeral Joint	☐ R ☐ L
Subacromial Bursa	☐ R ☐ L
AC Joint	☐ R ☐ L
Biceps Tendon (long head)	☐ R ☐ L
Suprascapular nerve block	☐ R ☐ L
Elbow	
Elbow joint	☐ R ☐ L
Lateral epicondyle	☐ R ☐ L
Medial epicondyle	☐ R ☐ L
Olecranon bursa	☐ R ☐ L
Wrist and Hand	
Radiocarpal Joint	☐ R ☐ L
CMC Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
MTP Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
Carpal Tunnel	☐ R ☐ L
Flexor/Trigger Finger	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
Knee	
Knee Joint	☐ R ☐ L
Hip and Pelvis	
Hip Joint	☐ R ☐ L
Greater Trochanteric Bursa	☐ R ☐ L
Meralgia Paresthetica	☐ R ☐ L
Ankle and Foot	
Ankle Joint	☐ R ☐ L
Subtalar Joint	☐ R ☐ L
MTP Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5

Non OHIP Services

☐ Platelet Rich Plasma
☐ Visco supplementation
☐ Please indicate site of injection __________



WOODSTOCK HOSPITAL
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INTERVENTIONAL PAIN REFERRAL FORM

Criteria for assessment:

- They must have a Primary Care Provider that does shared care model and is willing to act on recommendations provided
- The referring provider understands the role of this clinic is to provide diagnostic and therapeutic injections to assist in managing your patient's pain
- The referring provider will follow up with the patient following the injection and should they find this functionally beneficial, the referring provider will order ongoing injections as needed based on their assessment
- The referring provider will provide periprocedural guidance to the patient for holding any anticoagulation for procedure as indicated
- The referring provider has correlated clinical findings/testing with the patient and is confident on the diagnosis and plan along with selecting the appropriateness of the injection and requesting diagnostic and therapeutic interventions to help assist in managing your patient's pain
- The referring provider agrees to order the appropriate medications for the patient and ensure anticoagulation advice had been provided prior to the process
- Provider Checklist (the referral will not be considered complete without the following:)

☐ Up−to−date medications list
☐ Cumulative Patient Profile (CPP)
☐ Imaging (please select one):
  ☐ Imaging not attached but available on Clinical Connect
  ☐ Imaging completed in a private center and attached
  ☐ Imaging ordered but pending: Appointment date (mmm,dd,yyyy):____________ and location of scan: ____________
  ☐ Imaging attached (MRI, Xray, CT, Bone Scan as indicated above)
☐ Patient has been referred to any pain clinics and/or procedures (please attach notes/consults)

By signing below, you agree to the above:

Printed name of referring physician: ______________________________

Signature of referring physician: ______________________________

Date (mmm,dd,yyyy): ______________________________

Please fax completed referral and all supporting documentation to Central Bookings at 519-421-4238

If you have any questions, please call Diagnostic Imaging at 519-421-4211 Extension 2001