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** ☐ **Self Pay** ☐ **Routine** ☐ **Urgent**

Clinical History: (must be completed)

Allergies: ☐ Xray/contrast dye ☐ Latex ☐ Other _____
Medications: ☐ Antibiotics ☐ Other _____
☐ Anticoagulation _____
Patient has been provided instructions to hold anticoagulation*? ☐ Yes ☐ No
***Repeat injections will not be booked unless specifically requested**

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

Spinal Procedures (will be completed with corticosteroid)

Lumbar ☐ Facet Joint Injection T ☐ Medial Branch Block T ☐ Epidural Steroid Injection **(Interlaminar)	☐ L1–L2 ☐ R ☐ L ☐ L2–L3 ☐ R ☐ L ☐ L3–L4 ☐ R ☐ L ☐ 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 ☐ Coccyx Injection T	☐ Caudal epidural
Cervical ☐ Facet Joint Injection T ☐ Medial Branch Block T ☐ Epidural Steroid Injection ** *(Interlaminar)*	☐ C3–C4 ☐ R ☐ L ☐ C4–C5 ☐ R ☐ L ☐ C5–C6 ☐ R ☐ L ☐ C6–C7 ☐ R ☐ L ☐ C7–T1 ☐ R ☐ L
Thoracic ☐ Facet Injection T at _____ ☐ Epidural Steroid Injection ** *(Interlaminar)*	☐ Other (please specify) _____

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

Peripheral Joint Procedures T (will be completed with corticosteroid)

Shoulder Glenohumeral Joint Subacromial Bursa AC Joint	☐ R ☐ L ☐ R ☐ L ☐ R ☐ L
Elbow Elbow joint	☐ R ☐ L
Wrist and Hand CMC Joint MCP Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5 ☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
Knee Knee Joint	☐ R ☐ L
Hip and Pelvis Hip Joint Greater Trochanteric Bursa	☐ R ☐ L ☐ R ☐ L

Office use Only

WOODSTOCK HOSPITAL
Woodstock, ON

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 our role 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 and manage post procedure pain that may arise
- 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
- The referring provider acknowledges the patient is aware of the referral. The patient is aware the role of the clinic is limited to interventions and the appointment is for an injection for diagnostic and/or therapeutic purposes.

Provider Checklist **(the referral will not be considered complete without the following:)**

☐ Up–to–date medications list (or patient has been instructed to bring medications to appointment)

☐ 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