INTERVENTIONAL PAIN REFERRAL FORM

PATIENT INFORMATION

Name: _____

Email: _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Home phone: _____ **Cell phone:** _____

DOB: mmm dd yyyy ☐ **Male** ☐ **Female**

Health card number: _____

☐ **WSIB** ☐ **Routine** ☐ **Urgent**

Clinical History:

PHYSICIAN INFORMATION

Referring Provider: _____

Billing number: _____

Phone number: _____

Fax number: _____

Copy to: _____

Allergies: ☐ Xray/contrast dye ☐ Latex ☐ Other _____

Medications: (Please Attach) ☐ Antibiotics ☐ Anticoagulation

Patient has been provided instructions to hold anticoagulation*? ☐ Yes ☐ No

FOR REFERRER: Number of repeats/year ☐ 1 ☐ 2 ☐ 3

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

Spinal Procedures (will be completed with corticosteroid)

Lumbar

☐ Facet Joint Injection[T] at _____

☐ Epidural Steroid Injection** at _____

Sacrum

☐ Sacroiliac Joint injection[T] ☐ R ☐ L

☐ Coccyx Injection[T]

Cervical

☐ Facet Joint Injection[T] at _____

☐ Epidural Steroid Injection**

Thoracic

☐ Facet Injection[T] at _____

☐ Epidural Steroid Injection**

☐ Intercostal Nerve Block[T]

☐ **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**

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

☐ Occipital Nerve Block

☐ Botox for chronic migraine (non OHIP)

OFFICE USE ONLY

Peripheral Joint Procedures[T] (will be completed with corticosteroid)

Shoulder	
Glenohumeral Joint	☐ R ☐ L
Subacromial Bursa	☐ R ☐ L
AC Joint	☐ R ☐ L
Biceps Tendon (long head)	☐ R ☐ L
Elbow	
Elbow joint	☐ R ☐ L
Lateral epicondylitis injection	☐ R ☐ L
Medial epicondylitis injection	☐ R ☐ L
Olecranon bursa	☐ R ☐ L
Wrist and Hand	
Radiocarpal Joint	☐ R ☐ L
CMC Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
MCP Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5
Carpal Tunnel	☐ R ☐ L
Knee	
Knee Joint	☐ R ☐ L
Hip and Pelvis	
Hip Joint	☐ R ☐ L
Greater Trochanteric Bursa	☐ R ☐ L
Ankle and Foot	
Ankle Joint	☐ R ☐ L
MTP Joint	☐ R ☐ L ☐1 ☐2 ☐3 ☐4 ☐5

Non OHIP Services

☐ Visco supplementation

☐ Please indicate site of injection _____

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 (For instance, imaging and/or diagnostic and/or specialist referrals and/or medications as may be deemed appropriate)
- 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 and agrees to order the medications recommended by clinic during assessment.
- 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 and understands that the procedure requested may be changed based on the assessment at time of consultation.
- Provider Checklist (the referral will not be considered complete without the following:)

☐ Up–to–date medications list (Please instruct patient to bring this with them to their appointment)

☐ 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 the Woodstock Rehabilitation Clinic at 519-421-4079

If you have any questions, please call the Woodstock Rehabilitation Clinic at 519-421-4224