Providence Care

St. Mary's of the Lake Hospital

CHRONIC PAIN REFERRAL FORM

PERSONAL HEALTH INFORMATION

Please direct referral to Dr. (circle one):

Dubin / Faris / Ruggles / Shanks

Patient Name: ______________________ **D.O.B.:** ______________ (YYYY/MM/DD)

OHIP #: ______________ Version ________ **WSIB #:** ______________

Home Phone: ______________ **Work phone:** ______________

Referring Physician: ______________ **Family Physician:** ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

Work Status: ☐ employed (☐ full time ☐ part time) ☐ unemployed (☐ < 2 years ☐ > 2 years) ☐ retired

Disability Insurance: ☐ None ☐ ODSP ☐ OWP ☐ WSIB ☐ Private disability ______________

Litigation: ☐ none ☐ in progress ☐ completed

Pain History

Location: (all affected areas)

☐ back ☐ neck ☐ head ☐ abdomen ☐ shoulder ☐ leg ☐ arm ☐ face ☐ pelvis

☐ other ______________________________

Severity: ☐ mild (does not interfere with daily activities) ☐ moderate ☐ severe (interferes with most daily activities)

Duration: ☐ < 6 months ☐ 6 – 24 months ☐ 2 –5 years ☐ > 5 years

Current Underlying Diagnosis/Cause (if any): ______________________________

____

____

Associated Symptoms

Sleep disturbance: ☐ yes ☐ no Fatigue: ☐ yes ☐ no

Depressed mood: ☐ yes ☐ no Anxious mood: ☐ yes ☐ no

Relevant Past Medical/Surgical/Psychiatric History

Surgery related to current pain complaint: ☐ yes ☐ no

Details: ______________________________

____

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Substance Abuse: ☐ yes ☐ no

Details: ____________________

Psychiatric conditions: ☐ yes ☐ no

Details: ____________________

Other relevant (list): ____________________

Current Medications

Pain Medications:	Dose	Response
1.		
2.		
3.		
4.		

Other Medications: ____________________

Previous/discontinued Pain Medications

Medication:	Max. Dose	Reason Discontinued
1.		
2.		
3.		
4.		

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Non pharmacologic treatment to date

Comments

Physiotherapy: ☐ yes ☐ no ______________________________

Occupational therapy: ☐ yes ☐ no ______________________________

Psychology: ☐ yes ☐ no ______________________________

Complementary Medicine: ☐ chiropractic ☐ acupuncture ☐ massage

☐ other ______________________________

Previous Relevant Investigations (Please attach all reports)

	Yes/No	Comments
X-ray	______	______________________________
MRI	______	______________________________
CT	______	______________________________
EMG/NCS	______	______________________________
Other	______	______________________________

Previous Relevant Specialist Appointments (Please attach all reports)

	Yes/No	Comments
Other Pain Specialist	______	______________________________
Orthopedics	______	______________________________
Neurosurgery	______	______________________________
Psychiatry	______	______________________________
Physical Med. & Rehab	______	______________________________
Rheumatology	______	______________________________
Other	______	______________________________

Please provide contact information for person completing referral form, in the event that additional information is required. ______________________________

Fax completed form to Physiatry: (613) 544-4614