PES PROVIS PAIN MANAGEMENT CLINIC

1280 Old Innes Road, Suite 802, Ottawa, ON K1B 5M7 Telephone: 613-696-6936 Fax: **613-696-6937**

Patient's Name (Last Name / First Name)			**Referring Physician**	
Patient's Address or Label			**Physician's Address or Stamp**	
Health Card No. Version:	Sex Male ☐ Female ☐		**Physician's Address or Stamp**	
Date of Birth (mm/dd/yyyy)	Daytime Phone	Evening Phone	Physician's Phone No.	Physician's Fax No.

Required Medical Information

Pain Diagnoses:

Duration of Pain Condition: ☐ months: ☐ years: ☐ Others:

Please check all that apply from our referral criteria below:

- ☐ Nerve blocks (peripheral, plexus, sympathetic)
- ☐ Epidural injections (caudal, lumbar, thoracic, cervical)
- ☐ Joint injections (shoulder, knee, hip, sacroiliac, upper & lower limb)
- ☐ IV infusions (Lidocaine, Ketamine) mainly for generalized pain or refractory pain.

Required Medical History

- ☐ Attach all listed reports to the referral
- ☐ Detailed history of pain condition
- ☐ Medical history
- ☐ Current medication and dosages
- ☐ Previous treatments and medications tried for pain relief
- ☐ If CRPS is the reason for the referral, please send the completed Budapest criteria (See Appendix)

Mental Health diagnoses ☐ Yes ☐ No

Current Mental Health provider ☐ Yes ☐ No

☐ Reports available/attached

Investigations relevant to pain referral

Please check and attach reports (within the last 2 years)

☐ CT ☐ EMG

☐ MRI ☐ Ultrasound ☐ Other:

Current or Historical Substance ☐ Yes ☐ No

☐ Reports available/attached

Other Pain related Assessment/treatments

- ☐ Physical Interventions
- ☐ Psychosocial interventions:
- ☐ Reports available/attached

Has your patient attended a Chronic Pain Community self-management program? ☐ Yes ☐ No

Has your patient received treatment by another Pain Clinic? ☐ Yes ☐ No

If yes, please specify whom: Date:

☐ Reports available/attached

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