

Dear Doctor:

We understand that you wish to refer a patient with chronic non-cancer pain to our clinic for an assessment and opinion regarding the management of chronic pain. All patients referred must have a GP/FP. Our medical staff includes both specially trained GPs as well as Specialists. If you are working in an alternative payment group (ie.FHG, FHN) please indicate this on the referral.

Our clinic offers a comprehensive pain assessment, a diagnostic opinion and differential diagnosis, recommendations regarding an optimal treatment plan and a limited period of follow-up after implementation of the treatment plan. The components of the treatment plan offered “in house” may include any of the following: optimization of pharmacotherapy, nerve blocks and trigger point injections, and a psychoeducational pain self-management program. For other treatment modalities such as physical rehabilitation program, massage therapy, spinal adjustment, psychological treatments, Mindfulness Based Stress Reduction, etc., we will either refer patients to community resources or provide you with specific referral suggestions for the recommended treatment.

If part of our recommended pharmacotherapy plan includes a trial of opioid therapy, we will offer to start and stabilize the patient on medication but will eventually refer the patient back to you for ongoing treatment and follow-up. **This is an essential requirement of seeing your patient.** We will remain available to reassess your patient at any time if difficulties develop with the recommended treatment plan.

If our opinion is that some further investigation is indicated, we will advise you accordingly. We would be pleased to discuss any assessment or treatment issues with you by phone, at any time.

In order to ensure that our assessment is comprehensive, it is important that we have as much information as possible about your patient. We would appreciate your completion of the checklist on the attached page and forwarding copies of all relevant investigations, consultations and treatment reports to us by fax or mail.

Please feel free to contact me if you have any questions regarding our assessment and treatment process.

Regards,

Roman D. Jovey, M.D.
Program Medical Director

Please indicate whether your practice is HSO ___ FHG ___ FHN ___ Fee for Service ___ Other ___

To be seen by: first available CPM doctor ___ Specific CPM doctor _____

Referring MD Name: MD billing number:

MD Address:

MD Phone number: Back Line: Fax:

Patient Name: Patient HCN:

Patient Address: Patient phone number:

Patient DOB:

Is this a WSIB case? _____ WSIB claim No:

Current Pain Diagnosis:

How long has the patient had chronic pain?:

Current Treatments (attach list if insufficient space):

Any known history of alcohol or drug abuse/addiction? ____

Previously tried treatments (please check all that apply): Physio ___ Psychological ___

Nerve blocks ___ Acupuncture ___ TENS ___ Acetaminophen ___ NSAIDs/COXIBs ___

Tricyclics: _____ other antidepressants: _____ Cannabinoids _____

Antiepileptics: carbamazepine ___ gabapentin ___ pregabalin ___ topiramate ___ others _____

Opioids: Short-acting ___ If long-acting opioids, which ones: _____

Multi-disciplinary Pain Program? (where and when) _____

Surgical (what and when): _____

I attach a copy of the following reports:

Investigations: Imaging reports ___ Relevant labwork ___ EMG/NCS ___

Consults: Neuro ___ Ortho ___ Neurosurg ___ Rheum ___ Physiatry ___ Psych ___ Pain ___

I acknowledge that I have read the conditions of referral and will resume care of my patient after discharge from CPM

Signature: _____ **Date:** _____