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. Other treatment modalities including a physical rehabilitation program, massage therapy, spinal adjustment, psychological treatments, acupuncture, and Mindfulness Based Stress Reduction are now available on site, if felt to be beneficial by the consulting physicians.

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 treament 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

CPM – Centres for Pain Management – Hamilton
1605 Main St. West, Hamilton ON L8S 1E6
Phone: 905-574-4911 Fax: 905-574-8290
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Please indicate whether your practice is HSO___ FHG____FHN____Fee for Service___Other_____

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

Multi-disciplinary Program if appropriate_____

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: MVA Case?_____ MVA claim No:

Is this patient receiving disability benefits?_____

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:_____

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