



**Providence  
Health Care**

**Pain Management Program**

St. Paul's Hospital  
1081 Burrard Street  
Vancouver, BC V6Z 1Y6

Phone: 604-806-8824

Fax: 604-806-9117

Website: [www.providencehealthcare.org/pain-outpatient-clinics](http://www.providencehealthcare.org/pain-outpatient-clinics)

**Pain Management Program Description:**

- The interdisciplinary Pain Management Program is for patients requiring treatment for pain that has been unresponsive to conventional treatment (e.g. physiotherapy, NSAIDs).
- Emphasis is placed on self-management and rehabilitation. All patients will participate in self-management classes if deemed suitable.
- Patients may be recommended for interventional pain treatment.
- The consultative service provided by the Pain Management Program is not for long-term follow-up. The Program typically follows patients for 6 to 12 months. Patients must be followed by their Primary Care Provider during and after their participation in the program. The Pain Management Program is an interdisciplinary program and patients will be triaged according to our predetermined criteria and seen by the appropriate provider(s).
- The program does NOT assume prescribing, including opioids or other pain medications; the program may provide physician to physician consultation on dosing. The program can provide guidance for reducing opioid prescriptions.

**Inclusion Criteria:**

- Patient is 18 years of age or older
- Patient lives in Vancouver Coastal Health (VCH) catchment. Exception: If the service is not offered in your health authority, we may accept the referral
- The pain has been unresponsive to conventional treatment
- Patient is agreeable to learning self-management strategies and working with a multidisciplinary team
- Patient is agreeable to participate in a light-moderate activity or exercise program

**Exclusion Criteria:**

- Patient has an active untreated psychiatric condition (e.g. psychosis, severe depression, suicidality)
- Patient has active untreated substance use disorder
- Referral source's primary goal is medical legal consultation, or to obtain controlled substances, including opioid prescriptions
- Patient has an ongoing infection source without treatment
- Patient has previously received treatment at the SPH Pain Management Program for the same issue and has not followed treatment recommendations
- Patient has previously completed pain group management programs in tertiary centres, counseling and/or interdisciplinary consult and there are no new pain management approaches available
- Initial request is related to preparation of a return to work report or other documentation that is provided on cost recovery basis
- Patient is currently attending another pain medicine program which offers same services (e.g. Canadian Pain & Regenerative Institute, CHANGEpain, Jim Pattison Outpatient Care Pain Clinic, Victoria or Nanaimo Pain Program, Bill Nelems Pain & Research Centre, BC Women's Hospital programs)
- Patient would be better referred to a tertiary pain clinic specializing in the primary reason for referral
  - Send referrals for pelvic pain and endometriosis to the Centre for Pelvic Pain & Endometriosis: [www.bcwomens.ca/our-services/gynecology/pelvic-pain-endometriosis](http://www.bcwomens.ca/our-services/gynecology/pelvic-pain-endometriosis)
  - Send referrals for myalgic encephalomyelitis/chronic fatigue syndrome, fibromyalgia or symptoms attributed to chronic Lyme disease to the Complex Chronic Diseases Program (CCDP): [www.bcwomens.ca/our-services/specialized-services/complex-chronic-diseases-program](http://www.bcwomens.ca/our-services/specialized-services/complex-chronic-diseases-program)

**ST. PAUL'S PAIN MANAGEMENT PROGRAM  
REFERRAL**

Phone: 604-806-8824

Fax: 604-806-9117



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Pain Referral

**Date of referral:**
**Patient Name:** (Print clearly or attach label) \_\_\_\_\_

Date of Birth: (dd/mm/yyyy) \_\_\_\_\_ PHN: (personal health number) \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

 WorkSafe BC Claim # \_\_\_\_\_  ICBC Claim # \_\_\_\_\_ Other Claim # \_\_\_\_\_

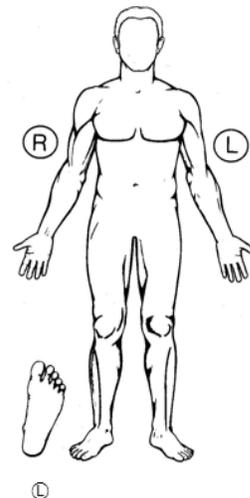
 Interpreter required?  No  Yes Language: \_\_\_\_\_

**Referring Primary Care Provider:** Name and specialty: \_\_\_\_\_ MSP# \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary Care Provider:** Name: \_\_\_\_\_ MSP# \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Area of Pain for Treatment (circle)**

**Urgency:**
 Urgent (within 4 weeks) – Reason (e.g. *complex regional pain syndrome, acute post-operative pain*):

 Semi-Urgent (within approximately 6 months) – Reason:

 Elective (within approximately 6 to 12 months) – Reason:

**Duration of pain:**
 Less than 3 months

 3 to 6 months

 More than 6 months

 For more information, including inclusion/exclusion criteria, please visit our website: [www.providencehealthcare.org/pain-outpatient-clinics](http://www.providencehealthcare.org/pain-outpatient-clinics)

**Diagnosis of Complex Regional Pain Syndrome?**

No

Yes:  less than 12 months  
 12 months or more

**Reason for Referral** (check all that are applicable):

Self-management/interdisciplinary programs

Pain specialist consultation

Request for specific intervention (specify): \_\_\_\_\_

Additional details attached

**History, Previous Treatment, and Goals of Treatment:** (e.g. able to exercise again, able to do hobbies again)

\_\_\_\_\_

**Expectation:**  Multidisciplinary group  Intervention  Opinion only

**DOCUMENT CHECKLIST**  
**Our triaging physician MUST have the following documents to review this referral. If investigation is pending, please attach referral/requisition form.**

	Report attached	Referral attached
• Complete current medication and allergy list	<input type="checkbox"/>	<input type="checkbox"/>
• Health history: physical exam results, medications tried, medical, surgical and psychiatric history	<input type="checkbox"/>	<input type="checkbox"/>
• Consultation notes from or referrals to specialists, including pain specialists	<input type="checkbox"/>	<input type="checkbox"/>
• Recent relevant investigations		
○ X-ray of specific joint being assessed (less than 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
○ Nuclear medicine bone scan of pain area (less than 6 months, optional)	<input type="checkbox"/>	<input type="checkbox"/>
○ CT or MRI of spine (following onset of pain or change in symptoms; preferably less than 12 months)	<input type="checkbox"/>	<input type="checkbox"/>
○ CT or MRI of head (less than 24 months, required for headache patients)	<input type="checkbox"/>	<input type="checkbox"/>

I have read the description of the St. Paul's Hospital Pain Management Program and reviewed the inclusion and exclusion criteria. The primary care provider is aware of this referral and has agreed to accept responsibility for ongoing care.

**Referring Provider:**

\_\_\_\_\_  
Signature Printed name MSP #

**FOR PAIN MANAGEMENT PROGRAM USE ONLY**

**This referral will be triaged. For prompt booking, please ensure all sections are fully completed.**

**Acknowledgement of referral** (to be completed within 10 business days): This referral has been triaged and our office will contact your patient within the next \_\_\_\_\_ weeks / months (circle one) to make an appointment.

Your patient is booked to see a specialist on: Date: \_\_\_\_\_ Time: \_\_\_\_\_

We will notify your patient

We require additional info before we can book an appointment for this patient: \_\_\_\_\_

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