

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

Chronic Pain Centre Referral

- Please Fax completed form to the Chronic Pain Centre at 403.209.2954 or Call 403.943.9900.
- Referrals with missing or incomplete information will not be processed

Chronic Pain Centre

The Chronic Pain Centre (CPC) is a one-year tertiary interdisciplinary program for patients with complex chronic pain. Patients must be able to engage in multiple appointments and group sessions over a one-year period. Our mission is to educate and empower people with chronic pain to achieve mental and physical well-being.

Patient Address

Phone

Referring Physician/Nurse Practitioner (NP)

Primary Care Physician/NP *(if different than referring provider)*

Name *(Last, First name)*

Name *(Last, First name)*

Phone number

Phone number

Fax number

Fax number

Practitioner Identification Number

Practitioner Identification Number

Special Requirements

- Is Language Line or an interpreter required? *(please specify language)* _____
- Does patient have hearing, visual impairment? *(please specify)* _____
- Other: _____

Type of Referral *(Check only one option)*

- 1- year interdisciplinary program
- MD to MD telephone consult
- MD to Pharmacist telephone consult
- Fibrofocuss *(for patients with primary diagnosis of fibromyalgia)*
- Neuromodulation assessment
- Neuromodulation nursing care only
- Requirements for Fibrofocuss:** Must be available 3 days/week from 10am to 3pm for 8 consecutive weeks or on the weekends. Must have Internet access and a Smartphone. Group-only treatment program on Zoom.

Referral Criteria *(Answer the following questions before proceeding with referral for the 1-year program)*

Has the patient received chronic pain services available in the community? *(eg. Primary Care Network pain services, Alberta Healthy Living chronic disease workshops)*

- Yes No ► *if no, see the list of options that might be suitable to refer your patients to.*

Does your patient understand that this is an intensive one-year program focused on self-management and function, and that we are not a diagnostic service?

- Yes No ► *if no, refer to the program when the patient understands and agrees that the program is right for them.*

Does the patient have a primary care provider who will continue to manage prescriptions and other care needs? *(i.e., physician/NP)*

- Yes No ► *if no, refer to the program when the patient has a primary care provider**

Is the patient currently residing in Alberta and has a valid Alberta Health Care Number?

- Yes No ► *if no, do not refer to the program.*

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Chronic Pain Centre Referral

Referral Criteria Continued

Is the patient at least 18 years of age?

Yes No ► *if no, refer to the Pediatric and Adolescent Complex Pain Clinic at the Alberta Children Hospital.*

Is the patient cognitively capable of completing a one-year program? Yes No ► *if no, do not refer to the program*

If the patient has a significant physical health condition, is the patient in a stable condition?

Yes No ► *if no, do not refer to the program until the patient is stable enough to commit to this intensive one-year program.*

Does the patient have an active cancer diagnosis? No Yes ► *if yes, do not refer to the program*

Does the patient have significant mental health issues that would preclude them from participating in an intensive one-year self-management program?

No Yes ► *if yes, do not refer to the program until the patient is stable enough to commit to this intensive one-year program.*

Does the patient have untreated/uncontrolled addictions to controlled substances?

No Yes ► *if yes, do not refer to the program until the patient has received addiction treatment and is stable enough to commit to the intensive one-year program.*

Are you referring to the CPC for chronic migraines?

No Yes ► *if yes, refer to Neurology Central Access and Triage (NCAT) instead.*

Has the patient participated in an interdisciplinary chronic pain program before or are they currently attending one?

No Yes ► *if yes, indicate which one? _____*

Note: We will accept referral of WCB patients for either a telephone consultation with a pain specialist or full one-year program. Approval from the WCB must be obtained prior to referring.

If unable to refer to the CPC based on above criteria, but advice on pain management is needed, consider choosing the **MD to MD Consult** or the **pharmacology telephone consult** options. Other advice options include **eReferral Advice Request** and **Specialist Link**. Information on how to access eReferral Advice Request and Specialist Link, in addition to other chronic pain resources in the community, is on the Alberta Referral Directory.

Reason for referral *(Check the appropriate box and describe the nature of pain and location)*

Chronic neuromusculoskeletal pain

Chronic pelvic pain *(female)*

Chronic headache *(post-traumatic/cervicogenic/post-concussion)*

Complex Regional Pain Syndrome

Date of Injury *(dd-Mon-yyyy)* _____ Type of Injury _____

Limb involved _____

Check all that apply:

Pain to touch *(allodynia and/or hyperesthesia)* Edema Erythema/Rubor Temperature Changes

Other _____

Diagnoses

Primary Pain Diagnosis and Location

Additional Diagnoses

Name	Signature	Designation	Date <i>(dd-Mon-yyyy)</i>
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