Chronic Pain Services
REFERRAL FORM

Date referred (YYYY-MM-DD): ________________ Fax Number: 902–473–4126

Referral will be triaged to urgency level and provincial location. Patient will be contacted with next available appointment.

✓ please ensure that appropriate investigations have been completed
✓ do not attach test results completed within the Nova Scotia Health Authority. Do include reports from private clinics.

<table>
<thead>
<tr>
<th>Urgency Level: indicate your assessment of urgency level by completing one of the boxes below</th>
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<tr>
<td>☐ Level 1 – Urgent referral&lt;br&gt; Patient is palliative with less than 6 months life expectancy. Requesting urgent anesthesia assessment for block procedure or other treatment.</td>
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<td>☐ Level 2 – Fast track referral&lt;br&gt; - Acute disc and sciatica (onset less than 6 months)&lt;br&gt; - Complex regional pain syndrome (onset less than 6 months)&lt;br&gt; - Post Herpetic Neuralgia (onset less than 6 months)&lt;br&gt; - Post–surgical neuroma (onset less than 6 months)</td>
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<td>☐ Level 3 – Regular referral. Check the treatment stream below that best meets the patient’s needs. &lt;br&gt; STREAM I (wait-time is shorter than STREAM II)&lt;br&gt; - Pain Self–Management group Program&lt;br&gt; - allied health team provide education and strategies to help with pain relief and quality of life.&lt;br&gt; - patient will commit to regular attendance, active participation &amp; willingness to implement new strategies&lt;br&gt; STREAM II&lt;br&gt; - Physician assessment&lt;br&gt; - Pharmacotherapy&lt;br&gt; - Interventional treatment&lt;br&gt; - Recommendations for Stream I as needed</td>
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Previous Treatment: indicate the treatment(s) trialed at the primary care level and/or other clinics

Pharmacotherapy: ☐ anticonvulsants ☐ antidepressants ☐ opioids ☐ cannabinoids ☐ acetaminophen ☐ NSAIDs
☐ Psychology ☐ Physiotherapy ☐ Pain self–management program ☐ Block procedure/injection. type ________________
☐ Previously seen by another pain specialist/clinic. Please specify ________________
☐ Other ________________

Description of Pain: help us understand THE REASON FOR THIS REFERRAL by completing the section below

Brief history of pain. Please specify the primary site of pain and onset:

____________________________________________________________________________________

Specific clinical question/request:
____________________________________________________________________________________

Referring Practitioner: referrals will be returned if form is incomplete

Name (print clearly): __________________________ Signature: __________________________ Direct Phone Number: __________________________

Name of Primary Care Provider if different from referring practitioner: __________________________