RCH BLOCK CLINIC REFERRAL

PATIENT NAME: _____
Surname (PLEASE PRINT CLEARLY) Given Middle

ADDRESS: _____

DATE OF BIRTH: _____ (dd/mm/yyyy) PHN (Personal Health Number) _____

CONTACT NUMBERS: Home _____ Work: _____ Cell: _____

MRN (Medical Record Number) _____ WCB#: _____ ICBC#: _____

Other Health Care Plan: **Expedited claim Y / N**

REFERRING PHYSICIAN: _____ MSP BILLING #: _____ PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

SIGNATURE OF REFERRING PHYSICIAN: _____ ☐ New Patient ☐ Re-referral

• Referring Physician agrees to participate with suggested regimen of therapy that may include the prescribing and monitoring of opiate analgesics? Y N

PAIN DIAGNOSIS: _____

☐ Malignant Pain ☐ Radicuopathy ☐ Ischemic Pain ☐ Peripheral Vascular Disease (PVD)
☐ Neuropathic ☐ Visceral Pain ☐ Cardiac ☐ CRPS (Complex Regional Pain Syndrome)
☐ Somatic pain ☐ other: Please specify: _____

DURATION OF PAIN: ☐<1 month ☐ 1-3 months ☐ 3-12 months ☐ 1-3 years ☐>3 years

PERSONAL MEDICAL HISTORY:

☐ Ischemic Heart Disease ☐ Stroke ☐ Hypertension ☐ Sleep Problems
☐ Thyroid Disease ☐ Diabetes ☐ Dementia ☐ Gastrointestinal Disorder
☐ Renal Insufficiency ☐ PVD ☐ Fibromyalgia ☐ Bleeding/Clotting Disorder
☐ COPD ☐ Anxiety ☐ Depression Other please specify: _____
☐ Anticoagulation: Please Specify: _____ (IF TAKING COUMADIN MAY REQUIRE D/C & INR PRIOR TO INJECTION) _____
☐ List Specialists/Services Involved: _____

DIAGNOSTICS: ATTACH REPORTS

☐ CT Scan ☐ Specialist Consult Reports
☐ X-Ray ☐ Nuclear Medicine
☐ MRI ☐ Physio/OT Assessment
☐ Other: Please specify (including laboratory investigations) _____

ALTERNATIVE TREATMENTS:

☐ Chiropractic ☐ Acupuncture ☐ Physio
☐ Psychology ☐ Topical Cream ☐ Tens
☐ Massage ☐ Herbal ☐ Other

INCITING EVENTS:

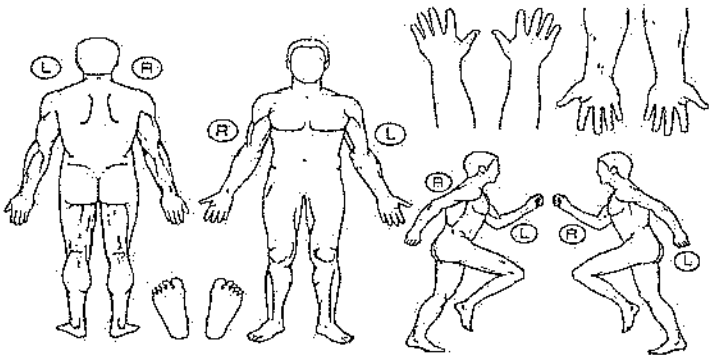
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY: _____

LIST OF CURRENT AND PAST MEDICATIONS:
PLEASE ATTACH A CURRENT AND PAST LIST.

ALLERGIES: _____
ALCOHOL (DRINKS/DAY) _____
ILLICIT DRUGS: _____
SMOKING: _____
SOCIAL ISSUES: _____

Pain Diagram



Location of Pain : _____

Procedure Request Only:

☐ Epidural Steroid (trans- foraminal trans- laminar
☐ Medial branch block or facet block
☐ Selective nerve root block
☐ Sympathetic block (Stellate or Lumbar)
☐ Neuroblative (celiac plexus, RF, etc)
☐ Other: _____

Please Complete & Fax to:
604-520-4188