Toronto Academic Pain Medicine Institute

External referral form
Women's College Hospital
76 Grenville Street, 3rd Floor
Toronto, Ontario M5S 1B2
Phone: 416-323-6269
Fax: 416-323-2666

PATIENT INFORMATION (Affix patient label/ identification here)

Name: _____

Date of birth: _____
DD / MM / YYYY

Health card: _____ Version code: _____

Address: _____

Please fax all five pages of the referral form together with requested imaging and consult notes to Toronto Academic Pain Medicine Institute (TAPMI) Central Intake at **416-323-2666.**

Your patient's referral will be assessed by TAPMI Central Intake (located at Women's College Hospital) and sent to the appropriate site with the **next available appointment.** TAPMI is a comprehensive virtual network of pain management services in downtown Toronto. The participating hospitals are:

camh Centre for Addiction and Mental Health
Sinai Health System
St. Michael's Inspired Care. Inspiring Science.
UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute
WCHH Women's College Hospital Health care for women | REVOLUTIONIZED

If you have a site preference for your patient please indicate here:

_____.

Please note that this may increase your patient's wait time.

In the TAPMI model, primary care providers play an active role in the treatment of their patients. The TAPMI team will provide assessment and a care plan for your patient's chronic pain problem. In some cases, treatment may be initiated by TAPMI, however, once stabilized (6-24 months) the patient will be returned to you for ongoing care, including pharmacotherapy, with our continued support.

TAPMI physicians and nurse practitioners will not take over prescribing permanently.

Please note that a referral may be seen by any health discipline (Doctor, Nurse, Occupational Therapist, Pharmacist, Physiotherapist, Psychologist, Social Worker) in TAPMI.

Updated urgency level determined by TAPMI triage: _____

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Address: _____
Phone: _____ Alternate: _____
Patient gender: _____

To be filled by referring health care provider.
Please note: all patients must have a primary care provider

Interpreter required? ❑ Yes ❑ No If yes, language required _____
Alternative contact name, relationship and number _____

Referring provider contact information
Name_____ Phone number_____
Address_____ Fax number_____

Signature: _____ Billing number: _____

Primary care provider contact information ❑ **Same as referring provider**
Name_____ Phone number_____
Address_____ Fax number_____

Estimated pain problem start date _____ DD/MM/YYYY

Urgency level 1: *Optimal wait time* 5-10 business days
❑ Patient is palliative with a less than 3 months life expectancy

Urgency level 2: *Optimal wait time* 10 business days

Date of onset
_____
DD / MM / YYYY

❑ Acute intervertebral disc herniation or sciatica **(onset in the last 6 months)**
❑ Complex Regional Pain Syndrome **(onset in the last 6 months)**
❑ Post surgical nerve injury **(onset in the last 6 months)**
❑ Requires chronic pain management prior to surgery **(surgery within 6 months)**
❑ Suspected early post herpetic neuralgia **(onset in the last 6 months)**
❑ Traumatic nerve injury **(onset in the last 6 months)**
❑ Palliative with a 3-12 months life expectancy
❑ More than 200 mg/ day of morphine equivalent dose (MED) **AND** one or more of the following
  ❑ Concerning aberrant drug related behaviours(altering the route of delivery, accessing opioids from other sources)
  ❑ Benzodiazepine use
  ❑ Alcohol consumption

❑ **Urgency level 3: *Next available appointment*** All other types of pain (see page 3)

Patient has **radicular pain?** ❑ **Yes** ❑ **No**

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Patient gender: _____

Please indicate below the pain diagnosis for your patient.

Abdominal pain
- ❑ Abdominal pain
- ❑ Crohn's/Ulcerative Colitis or Irritable Bowel Syndrome

Headache
- ❑ Cervicogenic headache
- ❑ Cluster headache
- ❑ Migraine tension type headache
- ❑ Occipital Neuralgia
- ❑ Temporomandibular Joint Disorder
- ❑ Trigeminal nerve pain

Musculoskeletal pain (Neck & Back)
- ❑ Failed back surgery syndrome
- ❑ Joint pain, *location* _____

Low back pain
- ❑ Limb dominant
- ❑ Back dominant
- ❑ Non mechanical back pain

Neck Pain
- ❑ Limb dominant
- ❑ Neck dominant

- ❑ Sacro-iliac joint pain
- ❑ Whiplash-associated disorder

Neuropathic pain
- ❑ Complex Regional Pain Syndrome
- ❑ Multiple Sclerosis
- ❑ Painful diabetic neuropathy
- ❑ Phantom limb pain
- ❑ Post stroke pain
- ❑ Post surgical pain
- ❑ Post-traumatic or compression-related neuropathic pain
- ❑ Shingles and post herpetic neuralgia
- ❑ Traumatic nerve injury
- ❑ Trigeminal neuralgia and atypical facial pain

Opioid management/ Substance use
- ❑ Aberrant drug related behaviours
- ❑ Escalating opioid therapy
- ❑ Patient interested in tapering
- ❑ Substance Use Disorder

Is the patient aware of the referral?
❑ Yes ❑ No
Please explain _____

Pelvic pain
- ❑ Chronic Pelvic pain
- ❑ Endometriosis
- ❑ Interstitial Cystitis
- ❑ Vulvodynia

Widespread pain disorders
- ❑ Fibromyalgia
- ❑ Myofascial pain syndromes
- ❑ Sickle Cell disease
- ❑ Systemic Exercise Intolerance/Chronic Fatigue
- ❑ Osteoarthritis

Other
- ❑ Cancer pain
- ❑ Cancer pain (Palliative)
- ❑ Rheumatological conditions
- ❑ Traumatic Brain Injury
- ❑ _____

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Phone: _____ Alternate: _____

Patient gender: _____

Does the patient have

- ❑ Multiple areas of pain
- ❑ Single focus of pain
- ❑ Dermatomal distributions of pain

Purpose of referral

- ❑ Consultation/provide advice
- ❑ Treatment
- ❑ Specific service requested _____

_____

Patient treatment preference (select all that apply):

- ❑ TAPMI to decide on appropriate program for my patient
- ❑ Pharmacotherapy recommendations: ***pain clinics will not take over prescribing permanently***
- ❑ Interventional therapies such as nerve blocks and ablations
- ❑ Allied Health/ Self management

The following documentation must be attached. This referral will not be processed unless all relevant information is received.

- ❑ Medication list
- ❑ Health summary
- ❑ Specialist consultation notes relevant to pain management
- ❑ All relevant imaging

Type: _____ Date: ____/____/____
DD / MM / YYYY

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Patient gender: _____

Does the patient have a psychiatric diagnosis that may interfere with pain management?
❑ Yes ❑ No

Please specify and attach any relevant consultation notes _____

Has the patient been seen within the TAPMI partnership?

❑ Centre for Addiction and Mental Health Interprofessional Pain and Recovery Clinic
❑ Sinai Health System Wasser Pain Management Centre
❑ St. Michael's Hospital Interventional Pain Clinic
❑ Women's College Hospital Interventional Pain Clinic
❑ University Health Network, *please specify clinic name* _____

Date last seen
_____
DD / MM / YYYY

If no, has the patient been seen at another pain clinic or are they currently being managed by any pain clinic?

Name of clinic_____ Date last seen ____/____/____
DD / MM / YYYY

Name of clinic_____ Date last seen ____/____/____
DD / MM / YYYY

Name of clinic_____ Date last seen ____/____/____
DD / MM / YYYY

Reason and purpose of referral: