



Toronto Academic Pain Medicine Institute

External Referral Form C

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

Please fax all pages of the referral forms together with requested imaging and consult notes to Central Triage at Toronto Academic Pain Medicine Institute (TAPMI) at Women's College Hospital.
416-323-2666

Your patient's referral will be assessed and sent to the most appropriate service with the next available appointment. TAPMI is a comprehensive virtual network of pain management services in downtown Toronto. The participating hospitals are:



In partnership with:



St. Michael's
Inspired Care.
Inspiring Science.



Please note all patients must have a Primary Care Provider.

In the TAPMI model, Primary Care Providers (PCP) play an active role in the treatment of their patients. The TAPMI team will provide assessment and a care plan for our 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 the PCP 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 (Physician, Nurse Practitioner, Nurse, Occupational Therapist, Pharmacist, Physiotherapist, Psychologist, Social Worker). Please inform your patient that, if appropriate, they will be enrolled in a Pain Education course.

<https://tapmipain.ca/patient/managing-my-pain/>

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PATIENT INFORMATION (Affix patient label/ identification here)

Name: _____ Date of Birth: _____
Preferred Name: _____ DD/MM/YYYY
Health Card: _____ Version code: _____
Address: _____
Phone: _____ Alternate: _____
Gender: _____ Pronouns: He/Him She/Her They/Them
Other: _____

Date of referral: _____
DD / MM / YYYY

To be filled by referring health care provider to help direct referral within TAPMI.

Language with which the patient is more comfortable speaking with the provider:

English French Other _____

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

Active Workplace Safety and Insurance Board Yes No # _____ (if known)

Does the patient have a psychiatric diagnosis that may interfere with pain management?

Yes No Suspected

Please clarify: _____

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

Date: _____

St. Michael's Hospital Interventional Pain Clinic

DD / MM / YYYY

Women's College Hospital Interventional Pain Clinic

University Health Network, please specify clinic name: _____

Reason for referral and patient treatment preference/expectations:

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Main reason for referral select or specify:

Urgency level 1: *Optimal wait time 5-10 business days*

Patient is palliative with less than a 6-month life expectancy

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

- Acute intervertebral disc herniation or sciatica (**onset in the last 6 months**)
- Pain in pregnancy (**please include expected due date**)
- Complex Regional Pain Syndrome (**onset in the last 6 months, meets International Association for the Study of Pain diagnostic criteria**)
- Requires chronic pain management prior to surgery (**surgery within 6 months**)
- Suspected early post herpetic neuralgia (**onset in the last 6 months**)
- Refractory nerve pain (**onset in the last 6 months; i.e., post traumatic, post surgical**)
- More than 90 mg/day of morphine equivalent dose (MED) **AND** one or more of the following
 - Concerning aberrant drug related behaviours (substance use disorder)
 - Problematic benzodiazepine use
 - Problematic alcohol consumption

Urgency level 3: *Next available appointment*

Patient has **radicular pain**? Yes No

Abdominal pain: must have GI consult

- Abdominal pain
- Crohn’s/Ulcerative Colitis/ Irritable Bowel Syndrome

Headache

- Cervicogenic headache
- Migraine, Cluster, Tension headache
- Occipital Neuralgia
- Temporomandibular Joint Disorder
- Trigeminal nerve pain
- Medication overuse headache

Opioid management/Substance use

- Aberrant drug related behaviours
 - Escalating opioid therapy (seeking)
 - Patient interested in opioid management or tapering
 - Patient interested in cannabis for pain
 - Substance Use Disorder
- Has the referral for a substance use disorder or aberrant drug use been discussed with patient?*
- Yes No

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Reason for referral continued

Musculoskeletal pain

Low Back Pain

- Limb dominant
- Back dominant

Neck Pain

- Limb dominant
- Neck dominant

- Failed back surgery syndrome
- Joint pain, *location* _____
- Sacro-iliac joint pain
- Whiplash-associated disorder

Neuropathic pain (onset greater than 6 months)

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

Pelvic pain: must have Gyne or Urology consult

- Chronic Pelvic pain
- Endometriosis
- Interstitial Cystitis

Widespread pain disorder

- Myofascial pain syndromes
- Sickle Cell disease
- Osteoarthritis
- Fibromyalgia

Other

- Cancer pain (non-palliative)
- Rheumatological condition
- Traumatic Brain Injury
- _____

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

- Relevant medical history (attach Cumulative Patient Profile)
- Specialist consultation notes relevant to pain management (GI, Uro, Gyne, Surgical, Psychiatry etc...)
- All relevant imaging relating to referral form

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VIRTUAL CARE HEALTH EQUITY SCREENING

Does the patient have a computer, laptop or mobile device with a working microphone and front facing camera?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a reliable, secure and high-speed internet connection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have a safe and private location wherein they can participate in the video visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient have the English and computer literacy necessary to perform all of the tasks associated with setting up and navigating myHealthRecord, downloaded apps from app stores, and setting up the video visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are video visits culturally acceptable to this patient as a trusted form of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments: _____

PATIENT CONSENT FOR EMAIL TO BE USED FOR PATIENT PORTAL REGISTRATION

The TAPMI pain clinic at WCH uses a patient portal called myHealthRecord to connect with patients before and after their visit. myHealthRecord allows patients to more easily complete clinical documentation and receive the materials that help them prepare for their upcoming visit. WCH will use the email address provided below to send the patient an activation code for the myHealthRecord patient portal.

Please ensure the patient has consented to your office sharing their email address for this purpose, using the consent script included below:

“Women’s College Hospital uses a patient portal called myHealthRecord. Some of your clinical documentation may be completed ahead of the appointment using the patient portal. Are you comfortable with our office providing your email address to Women’s College Hospital so that they can send an activation code to you to register for myHealthRecord? The confidentiality of email cannot be guaranteed and is used only with your permission and at your own risk. No other personal health information will be sent to you over email. You can decide if you’ like to sign-up after reviewing the Terms and Conditions. myHealthRecord registration is optional and not having an account will not interfere with your care in any way.”

Patient consented to office sharing email with WCH for patient portal registration:

Yes – Patient’s email address:

No – Patient declined

No – Patient does not have email

Unable to consent patient to sharing email

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