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.**

Please inform your patient they are expected to attend TAPMI s Mandatory Orientation Session as part of the intake process. If patient does not attend the Mandatory Orientation Session and complete the intake process this referral will be closed. Please notify us if there is anything that would prevent the patient from attending the Mandatory Orientation Session.

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:

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.

Exclusion Criteria for TAPMI Referrals:

- Patients without a primary care provider
- Patients with an active WSIB
- Patients undergoing concomitant treatment by other pain clinics or seeing multiple providers simultaneously
- Patients having exhausted all treatment modalities, having seen multiple pain clinics and where the information forwarded to us allows us to conclude there is nothing further we can offer
- Patients with unstable, undiagnosed or untreated psychiatric comorbidities

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

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Date of referral: _______________
DD / MM /YYYY

PATIENT INFORMATION (Affix patient label/ identification here)

Name: ______________________ Date of Birth:____________ DD/MM/YYYY
Preferred Name:__________________
Health Card: ____________________ Version code: ________
Address: ____
Phone:________________ Alternate: _________________
Gender: ________ Pronouns: He/Him She/Her They/Them Other:_____________________

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 : ____

Primary care provider contact information: ***Referrals without a primary care provider will be declined***
Name: ______________________________________ Phone number: ____________________
Address: _____________________________________ Fax number: _______________________

Referring provider contact information: **Same as referring provider**
Name: ____ Phone number: ____________________
Address: ____ Fax number: ____________________

Signature: __________________________________ Billing number: __________________________

Estimated pain problem start date: ______________________________ DD/MM/YYYY **Active**

Workplace Safety and Insurance Board **Yes*** **No**

*Active cases will be declined

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

❑ Yes* ❑ No

* If yes, please include recent psychiatric notes

Has the patient been seen within the TAPMI partnership?

❑ Centre for Addiction and Mental Health Interprofessional Pain and Recovery Clinic
❑ Sinai Health 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:_________________
DD / MM / YYYY

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: ***We aim to see patients between 30 and 90 business days***

- ❑ Acute intervertebral disc herniation or sciatica **(onset in the last 6 months)**
- ❑ Pain in pregnancy **(please include expected due date)**
- ❑ Headache 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
- ❑ ____________________________________

<u>The following documentation must be attached.</u> 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
- ❑ Any pain clinic consult notes
- ❑ Currently there is no imaging for this patient

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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?	☐ Yes ☐ No
Does the patient have a reliable, secure and high-speed internet connection?	☐ Yes ☐ No
Does the patient have a safe and private location wherein they can participate in the video visit?	☐ Yes ☐ 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?	☐ Yes ☐ No
Are video visits culturally acceptable to this patient as a trusted form of care?	☐ Yes ☐ 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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