19/02/2025 15:12

fraserhealth

CHRONIC PAIN CLINIC – REFERRAL

Jim Pattison Outpatient Care and Surgery Centre

Form ID: MSXX104665F Rev: February 11, 2025 Page: 1 of 2

3rd Floor – Reception 3D 9750 - 140th Street, Surrey BC, V3T 0G9
T: 604-582-4587 F: 604-582-4591

Instructions

- The Chronic Pain Clinic is an interdisciplinary clinic and patients will be triaged according to our predetermined criteria and seen by the appropriate provider(s).
- The consultative service provided by the Chronic Pain Clinic is not for long term follow-up.
- Patients must be followed by their primary care provider during and after their participation in the program.
- The Chronic Pain Clinic is offered to patients living within the catchment area of Fraser Health Authority with some rare exceptions for those living outside this area.
- The clinic does not assume opioid prescribing or tapering or rotation.
- There are no addiction services in our clinic.

Fax referral with supporting documentation to 604-582-4591
Supporting documentation includes all consultation and investigation reports relevant to condition (e.g., X-ray, CT, MRI, US)

Patient Information

Referral Date (dd/mm/yyyy): _____ Interpreter Required: ☐ Yes ☐ No
If yes, language: _____

Legal Name: _____ Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex
Surname Given Name Middle

Home Address: _____
Street City, Province Postal Code

Date of Birth (dd/mm/yyyy): _____ Personal Health Care Number: _____

Preferred phone number: _____ Alternate number: _____

Email: _____

Referral Information

Referring Provider
Name: _____ MSP#: _____

Phone: _____ Fax: _____

Signature: _____

☐ WorkSafe BC Claim #: _____ ☐ ICBC Claim #: _____

☐ BCAA #: _____ ☐ Other: _____

Reason for Referral (select one option only):

☐ Medical Consultation (which may include consultation with allied health and/or nursing)
Reason for medical consult: _____

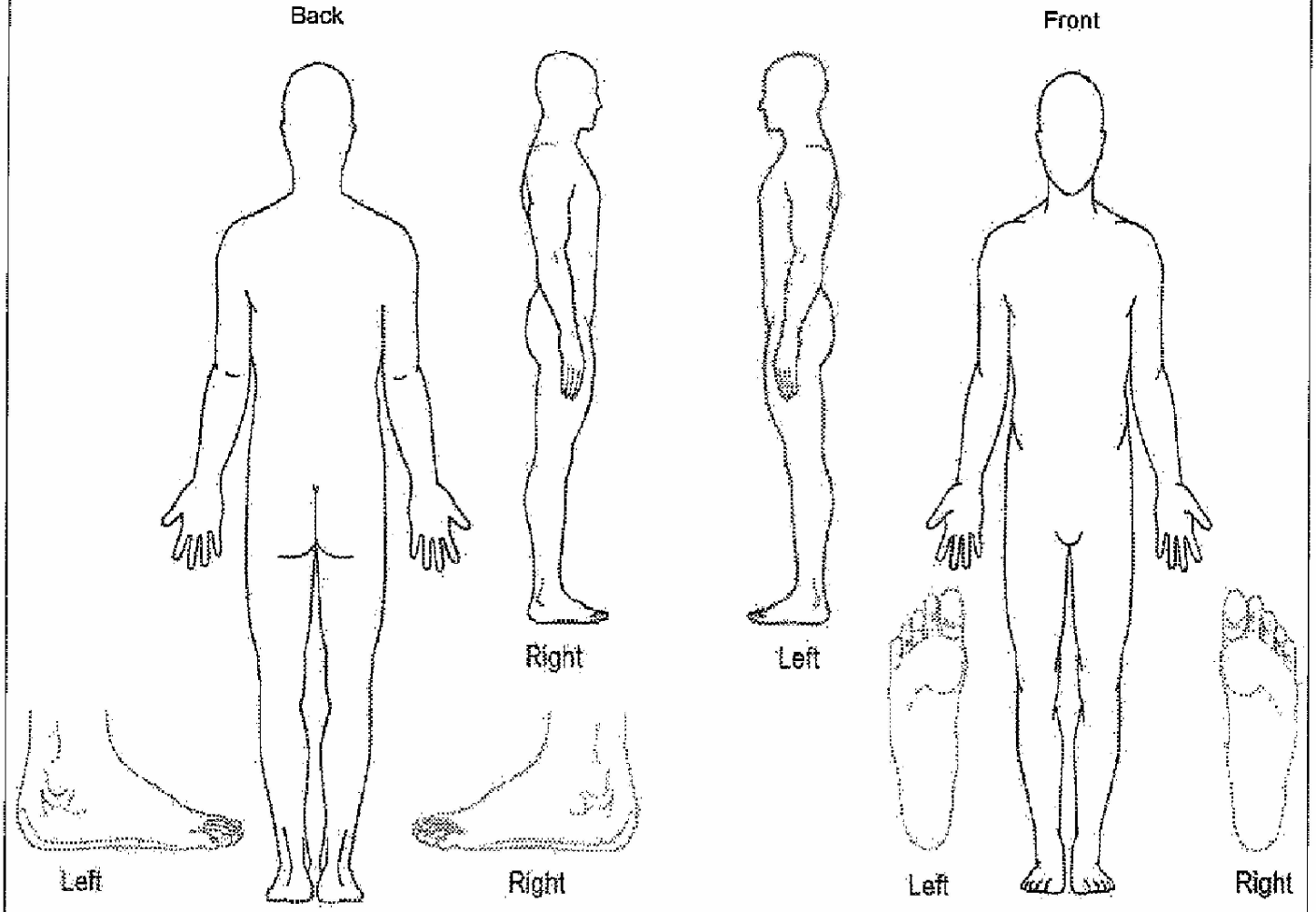
☐ Self-Management Education (select this option if no further assessment or intervention required)
2.5 hour virtual session once a week for 8 weeks on group education on chronic pain physiology and self-management skill building

Print Shop # 263563

CHRONIC PAIN CLINIC – REFERRAL

Jim Pattison Outpatient Care and Surgery Centre

Indicate specific location(s) of pain with an X:



Duration of Pain: ☐ 6 months ☐ 12 to 24 months ☐ 24 months or more

Pain Condition:

19/02/2025 15:11

fraserhealth

CHRONIC PAIN CLINIC – INTAKE

Jim Pattison Outpatient Care and Surgery Centre

Patient Reviewed

Form ID: PCXX106140C Rev: February 11, 2025 Page: 1 of 2

Please answer questions on page 1 and 2 to help our team know you better.

Last name: _____ First name: _____

Date (dd/mm/yyyy): _____ Personal Health Number (BC Services Card): _____

Person completing this form: ☐ Self ☐ Essential care partner (specify): _____

I need an interpreter: ☐ Yes ☐ No If yes, language: _____

☐ I would like appointment reminders, health information and other communications sent to me by email

Email: _____

What are your goals for this program?

For example: be more active, improve sleep, take part in specific activities.

_____

_____

_____

What do you believe is causing your pain?

_____

_____

How long have you had pain?

☐ Less than 6 months ☐ 6 to 12 months ☐ 1 to 3 years ☐ More than 3 years

Are there other specialists or services you see for your pain? ☐ Yes ☐ No

If yes, please tell us when, where and what treatments you had.

_____

_____

In the last 12 months have you had any tests, x-rays, MRI or CT scans related to your pain? ☐ Yes ☐ No

If yes, please specify: _____

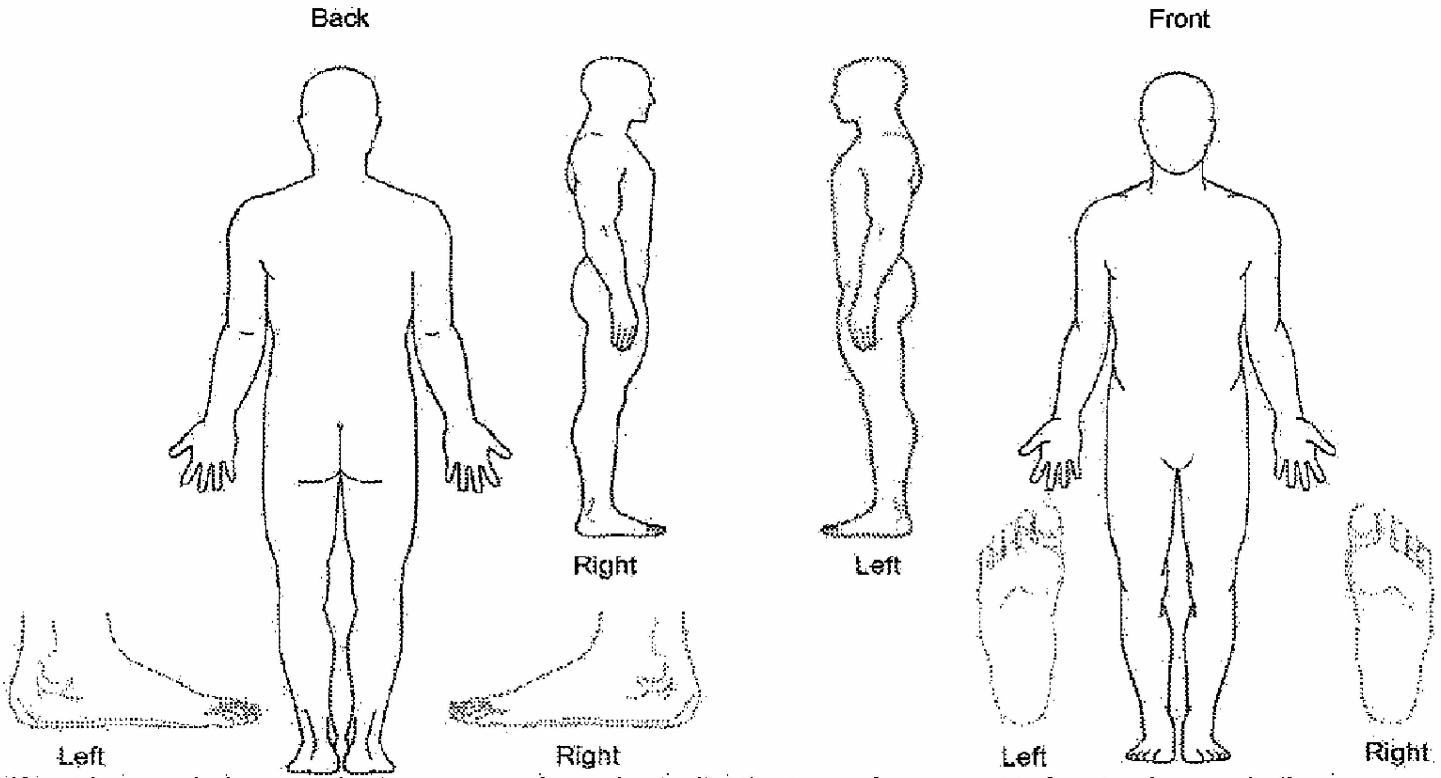
Please answer the following questions about your pain.

			Clinician Use Only	
Do you feel anxious?	☐ Yes	☐ No	GAD 7	☐ Yes
Do you feel depressed?	☐ Yes	☐ No	PHQ 9	☐ Yes
Do you feel afraid that activity will make your pain worse?	☐ Yes	☐ No	TSK	☐ Yes
Do you think about your pain **all the time**?	☐ Yes	☐ No	PCS	☐ Yes

CHRONIC PAIN CLINIC – INTAKE

Jim Pattison Outpatient Clinic Care and Surgery Centre

Mark with an **X** where you have pain.



If you have pain in more than one area of your body, list the areas from worst to least pain area in the spaces below.

1. _____ 2. _____ 3. _____ 4. _____

In the last 24 hours, how much relief have your pain treatments or medications provided?
Please select the one percentage that shows most how much RELIEF you have received

No relief Complete relief

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Select the number that describes how pain the past 24 hours has interfered with your:

	Has not affected										Very affected
	0	1	2	3	4	5	6	7	8	9	10
General activity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking Ability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Normal Work (includes work outside the home and housework)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relations with other people	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Enjoyment of life	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Total / 70											