The Ottawa Hospital

The Ottawa Hospital (TOH) Pain Clinic – Referral Information & Program Overview

External Pain Clinic Referral Form
The Ottawa Hospital Pain Clinic
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Program Overview

The TOH Pain Clinic is a comprehensive, interdisciplinary academic pain program. Our interprofessional approach addresses all factors influencing a patient's perception of pain. A patient's care plan may involve multiple specialists and team members, ensuring the most effective strategies to reduce chronic pain and improve function. Key principles of our program include:

- **Interdisciplinary, Stepped-Care Model**: Patient referrals will be reviewed, triaged, and recommended to the most appropriate provider(s) throughout their time in the clinic— including pain medicine specialists and physicians, resident and fellow physicians, medical students, a nurse practitioner, nurses, medical radiation technologists, psychologists, physiotherapists, an occupational therapist, and social worker — based on needs, preferences, goals, and readiness.
- **Consultative Model**: The Pain Clinic does not provide longitudinal care. All patients must have a primary care provider (PCP) or MRP who will assume responsibility for routine follow-up and implementation of treatment recommendations, including pharmacotherapy.
- **Mandatory Orientation:** All accepted patients must attend a Pain Education & Resource Session prior to consultation with a Pain Medicine clinician. Referrals will be closed if this step is not completed. Please identify any barriers to attendance in the referral.

Referral Requirements & Eligibility:

- Referrals can be submitted via EPIC, OCEAN e-referral, or fax.
- Referrals must address **one primary pain area** (exception: widespread/diffuse pain). Separate referrals and work-up are required for additional, distinct pain issues.
- Incomplete referrals will be closed – **all fields are mandatory**. Due to high volumes, we are unable to re-open incomplete referrals.
- For reasons of patient safety and care coordination, procedural interventions from other pain clinics or departments for the same area of concern are not permitted while the patient is under our care.

Inclusion Criteria (All Must Apply)	Exclusion Criteria
• Required work-up is complete at the time of referral • Patient is unresponsive to conventional therapy/ approaches to pain management. Referrals must demonstrate appropriate prior management (i.e., medication trials, physio, etc.) • PCP has signed the Terms of Agreement. If you are not the patient's PCP, please ensure the PCP's signature is obtained and included with the referral • Age ≥ 18+ (exceptions considered) • Patient or caregiver agrees to attend a one-hour Pain Education & Resource orientation Session	• Active referral to or care in another pain program or by pain specialist/interventionalist • Resides outside of Ontario (exceptions: Nunavut & Akwesasne) • Expectation of assuming longitudinal care • Patients having exhausted all treatment modalities, where the information provided allows us to conclude there is nothing further we can offer • Referral requests solely for: trigger point injections, IV infusion therapy, opioid prescribing/renewal/tapering, or assuming prescriptions. Treatment plans are determined at the discretion of the clinician.

Resources

- For more information on available services, please visit our website: The Ottawa Hospital | Pain Clinic
- We strongly encourage patients to leverage the education and self-management resources available to them through the Power Over Pain Portal

We appreciate your referral and look forward to working together in the shared care of your patient.

Patient Information

Legal Name: _____ Preferred Name: _____

DOB (dd/mm/yy): Gender :_____ Pronouns: ◯He/Him ◯She/Her ◯They/Them ◯: _____

HCN:_____ Version Code:_____ Address:_____

Phone: _____ Alternate: _____ Email:_____

Primary Language: ◯English ◯French ◯Other:_____

PCP Information

All patients require a PCP to assume follow-up care & recommendations. Refer to terms of agreement.

Name:_____ Address:_____

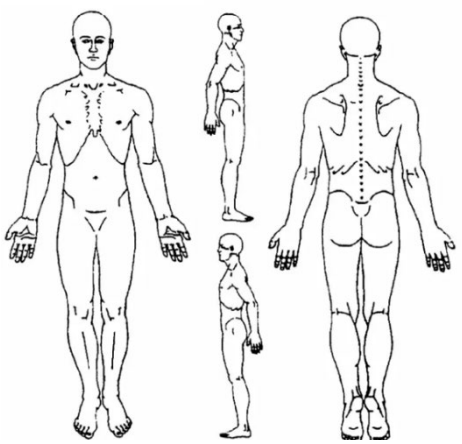
Phone: _____ Fax: _____ Billing Number:_____

Referral Reason

◯New Referral ◯Re-Referral: ◯Same Pain Area ◯New Pain Area

Note: **one** pain site to be addressed per referral, unless widespread/diffuse

a. Body Pain Diagram – Mark the primary source of pain with an "X" on the diagram & select the most appropriate primary pain site below:



❑ **Axial**
- ❑ Cervical ❑ w. radiculopathy*
- ❑ Thoracic ❑ w. radiculopathy*
- ❑ Lumbar ❑ w. radiculopathy*

❑ **Abdominal/Pelvic – Non-Gyne**

❑ **Abdominal/Pelvic – Gyne**
- ❑ Dysmenorrhea ❑ Endometriosis
- ❑ Painful bladder syndrome ❑ IBS
- ❑ Abdominal wall myofascial
- ❑ Vulvodynia
- ❑ Pelvic myofascial/ vaginismus

❑ **Chest**

❑ **Face**

❑ **Head**

❑ **Extremities**
- ❑ Upper ❑ R ❑ L ❑ Bilateral
- ❑ Upper ❑ R ❑ L ❑ Bilateral

❑ **Widespread/ Diffuse**

***If radicular symptoms are present, the following fields are mandatory:**

i. Radicular symptom onset: ◯<3mo ◯3-6mo ◯>6mo

ii. **Single** spinal level dermatome(s) affected (e.g., L5): _____

iii. Lower Extremity:
- **a.** Straight leg raise: ◯Positive ◯Negative
- **b.** For L4, L5, S1 – does the pain radiate past the knee? ◯Yes ◯No

iv. Upper Extremity:
- **a.** Spurling sign: ◯Positive ◯Negative
- **b.** For C6, C7, C8 – does the pain radiate to fingers? ◯Yes ◯No

b. Focused Physical Exam – Describe objective findings from the focused physical examination of the affected area.

c. Pain Duration: ◯<3mo ◯3-6mo ◯6-12mo ◯>12mo

Referral Reason Continued

d. Select all that Apply (* mandatory):

❑ Complex Cancer Pain	❑ CHEO Pediatric Transition	❑ Revascularization	❑ Sickle Cell Anemia
❑ Palliative (*Life expectancy: _____)	❑ Pregnant (*EDC: _____)	❑ Radiculopathy	❑ CRPS *(complete Budapest criteria)

e. Additional Details – include pain onset, inciting event, specific description of pain location, type, and suspected etiology.

_____

_____

_____

_____

f. Pain Impact on the Patient:

❑ Unable to work / attend school	❑ Pain interferes with sleep:	❑ Pain limits social interactions	❑ Pain impacts family functioning
❑ Pain affects mood	❑ Falling asleep	❑ Pain impacts mobility	❑ Pain affects ADLs or self care
	❑ Sustaining sleep		

g. Expectations of this Referral – What is the intended purpose or expected outcome of the referral? What functional outcome is the patient hoping to achieve (e.g., increased mobility, return to work, improved function in daily life)?

_____

_____

h. Has the patient been referred to another pain specialist, clinic or for interventional treatment? ◯ Yes ◯ No

i. Is the patient being referred as part of an eConsult recommendation? ◯ Yes (eConsult Attached) ◯ No

Pain & Medical History

a. Current/previous involvement with another pain specialist or interventional provider? ◯ Yes, Active ◯ Yes, Historical ◯ No

Name of provider/clinic: _____ ❑ Treatment History Attached

b. Trialed Therapy/Interventions to Date: Include details related to pharmacotherapy, interventional treatment, physical and psychosocial interventions, pain education or community chronic pain management programming.

_____

_____

_____

c. Mental Health History ◯ Yes (Reports attached) ◯ No

❑ Mental Health Diagnoses ❑ Current or history of substance use ❑ Other: _____

d. Patient Needs (Select those that apply & describe) ◯ Yes ◯ No

❑ Disability ❑ Communication or Comprehension Needs ❑ Barriers to In-Person or Virtual Care

❑ Service Animal ❑ Other

Describe: _____

_____

Additional Patient Considerations (Select All That Apply & Explain)

❑ Patient is aware that they may be seen by any clinician member of our interdisciplinary team.

❑ Patient agrees to participate in pain education & self-management strategies, if not an interventional candidate.

❑ Patient is aware of and agrees to this referral.

Imaging, Investigations and Consultations (Imaging Must Be Current, Within Last 24)

a. CHECKLIST – The following must be included and complete at the time of referral submission

- ❑ Medical History (including allergies)
- ❑ Detailed History of Pain Condition
- ❑ Pain Consults, Work-Up, Imaging
- ❑ Complete Medication List
- ❑ Mental Health History
- ❑ Signed Provider Terms of Agreement

Referrals should demonstrate appropriate prior management (e.g., medication trials, physiotherapy, or other relevant interventions) and work up. Referrals without prior management may be redirected for e-consult, where appropriate.

Pain Clinic Referring Provider Terms of Agreement

The Ottawa Hospital Pain Clinic is an interdisciplinary, tertiary care, academic clinic specializing in the assessment and management of chronic pain. The team includes pain medicine specialists and other physicians, resident and fellow physicians, medical students, a nurse practitioner, nurses, medical radiation technologists, psychologists, physiotherapists, an occupational therapist, and a social worker. The Clinic provides an interprofessional, patient-centered approach with an emphasis on education, self-management, and improving quality of life.

The Pain Clinic functions as a consultative service and does not provide longitudinal care or ongoing medication management. Pharmacotherapy recommendations may be communicated to the referring provider; however, responsibility for ongoing medical management remains with the patient's primary care provider. Sustained collaboration and information exchange with the referring provider are essential to ensure continuity and coordination of care.

To support appropriate triage and continuity of care, the following terms must be reviewed and accepted by the patient's primary care provider, or by the referring provider willing to assume this responsibility. Referrals that do not meet these criteria or are incomplete will be returned.

Referring Provider Acknowledgement:

By submitting this referral, I acknowledge and agree to the following:

- I confirm that all referral fields and investigations have been completed. I understand that incomplete referrals will be returned.
- I understand that an eConsult with a Pain Medicine Physician may be offered as the most appropriate initial intervention for my patient.
- I understand that the Pain Clinic is a consultative, tertiary care service. Pain providers may initiate assessment, treatment and/or recommendations; however, patients are typically discharged back to primary care for ongoing management within 12-24 months.
- I acknowledge that the referring provider is expected to be the sole prescriber of any pharmacotherapy and assume any recommendations provided by the Pain Clinic. If the patient's Primary Care Provider does not consent or is unaware of the referral, the referring provider agrees to implement TOHPC recommendations.
- I confirm that my patient has been informed of the Pain Clinic's interdisciplinary model of care and understands that they may be assessed and/or treated by any member of the team, including a pain medicine specialist or other physician, resident and fellow physicians, a nurse practitioner, nurses, psychologists, physiotherapists, an occupational therapist, and/ or a social worker.
- I confirm that my patient is not currently being followed by, or referred to, another pain clinic or interventional provider for the same pain concern.

❑ **I accept the above terms and conditions.**

Provider Name (printed): _____

Provider Signature: _____

Date: _____

Referral Guide for Common Pain Conditions (Non-Exhaustive List)			
Condition	**Required Work Up**	**Notes**	**Attached**
Abdominal Pain	• Abdominal U/S, CT, or MRI	• Preferred: GI/ Gen Surg consult	☐
CRPS	• Completed Budapest diagnostic criteria (see Appendix) • Acute and chronic causes of limb pain, swelling, dysesthesia identified.	• Clearly document pain area(s) on body pain diagram within referral	☐
Non- Radicular Axial Pain **(Cervical, Thoracic, Lumbar)**	• Advanced Imaging (CT/MRI) post-symptom onset • Specific, single dermatome must be outlined (see page 2) • Cervical – EMG/NCS; preferable: Spine or Physiatry consult • Thoracic – CT/MRI, chest x-ray – must have complete workup with etiology identified	• Clearly document pain area(s) on body pain diagram within referral • Acute radiculopathy presentations accepted to Acute Radiculopathy Clinic – limited pathway (~3-4 visits).	☐
Facial	• Advanced Imaging (CT/MRI) • Neurology or Neurosurgery consult		☐
Headaches	• Headaches: Advanced imaging (CT/MRI) • Neuro consult, where applicable • Concussion related: require concussion assessment (exclusion: head injury within 3-6mo)		☐
Extremities	• Wrist/Hand, Shoulder/Arm, Ankle/Foot – Xray, U/S, and/or MRI; EMG if neuropathic symptoms • Knee – Xray; MRI, (if Xray results are normal • Hip/Leg – Xray; MRI (if Xray results are normal); EMG if neuropathic symptoms	• Appropriate specialty consults as indicated	☐
Diffuse/ Widespread Pain (multiple locations) **Diagnoses such as:** • Fibromyalgia • Hypermobility/ EDS • Chronic Fatigue • Multiple joint osteoarthritis • Autoimmune conditions	**Labs**: • TSH, Free T3, T4; B-12, CBC, Ferritin • ANA, ESR, CRP, CK **Other:** • Preferred: 12-lead ECG (cardiac status) • Rheumatology consult, if labs reveal evidence of inflammatory disease (not required for fibromyalgia)	• NP Consult • Self-management pathway	☐
Gynecological Pelvic Pain	• Pelvic ± transvaginal gynecologic ultrasound	• While awaiting assessment, consider: • Hormonal menstrual suppression strategies for painful menstruation • Pelvic physiotherapy	☐
Non-Gynecological Pelvic Pain (i.e., painful bladder syndrome, interstitial cystitis)	• Urology consult • Abdominal/ Pelvic U/S		☐
Post Surgical /Post-Traumatic Pain	• Advanced Imaging post- symptom onset/ change • Applicable surgical/specialty reports		☐

Appendix

Budapest Criteria for Complex Regional Pain Syndrome (CRPS)

To make the clinical diagnosis, the following criteria must be met:

- ❑ Continuing pain, which is disproportionate to any inciting event.

- ❑ Must report at least one symptom in all four of the following categories:
  - sensory – reports of hyperaesthesia and/or allodynia
  - vasomotor – reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry
  - sudomotor/oedema – reports of edema and/or sweating changes and/or sweating asymmetry
  - motor/trophic – reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

- ❑ Must display **at least one sign** at time of evaluation in two or more of the following categories:
  - sensory – evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement)
  - vasomotor – evidence of temperature asymmetry (> 1 °C) and/or skin colour changes and/or asymmetry
  - sudomotor/oedema – evidence of edema and/or sweating changes and/or sweating asymmetry
  - motor/trophic – evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)

- ❑ There is no other diagnosis that better explains the signs and symptoms.