northern health
the northern way of caring

University Hospital of Northern British Columbia

Pain Services Referral

Patient's name Surname: First: Middle:		Date of birth	PHN
Address		Daytime phone	Alternate phone number
Referring physician	MSP number	Phone number	Fax number

Important instructions: *We expect that all appropriate initial investigations have already been performed by the referring physician. If the information is missing, the referral will be returned to the referring physician and the patient will* ***not*** *be wait-listed. We will contact the patient directly to set up an appointment. Please* ***do not*** *instruct patients to call regarding their consult appointment.*

☐ **Cancer** ☐ **Complex regional pain syndrome (CRPS)** ☐ **Chronic low back pain** ☐ **Neck pain**

Referring physician/nurse practitioner pain assessment

Duration of pain and cause if known: ______________________________

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Location of pain including any referred pain: ______________________________

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Neurological findings (i.e., numbness/weakness/radicular features down arms or legs): ______________________________

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Is this pain related to: ☐ WCB ☐ ICBC ☐ Medical legal

Is the patient on any of the following blood thinners? (Check all that apply.)

☐ **clopidogrel** ☐ **dabigatran** ☐ **heparin** ☐ **nadroparin** ☐ **rivaroxaban** ☐ **warfarin** ☐ Other: ___________

Please attach	Attached	Not available	Please attach	Attached	Not available
Current medication list	☐	☐	Relevant bone scan results	☐	☐
Relevant CT results	☐	☐	Relevant consults/reports from other physicians/specialist	☐	☐
Relevant MRI results	☐	☐	Surgical reports	☐	☐
Relevant x-ray results	☐	☐	Other:	☐	☐

Please fax completed referral and documents to 250-565-2160.

All incomplete referrals will not be processed and will be returned by fax.

For office use only

Date of referral:	Date physician reviewed:	Date of consultation: