Santé et Services sociaux Québec

DT9248

REQUEST FOR CONSULTATION – CHRONIC PAIN MANAGEMENT

For:

Patient Information

First and last name (at birth)

Sex ☐ M ☐ F

Birth date Year Month Day

Health insurance number

File number (internal use)

Address (No., St.)

City

Postal code

Area code Telephone no. (home)

Area code Telephone no. (other)

Name of family member or friend

Area code Telephone no.

Referring physician (or apply your stamp)

First and last name

Licence no.

Specify

☐ Family MD ☐ Other

Area code Telephone no.

Area code Fax

Attending physician ☐ Same as referring physician

First and last name

Licence no.

Specify

☐ Family MD ☐ Other

Area code Telephone no.

Area code Fax

Reason for request

Date Year Month Day

☐ New user ☐ Reassessment

Referral to pain clinic

☐ Medical opinion

☐ Targeted intervention/technique

☐ Medication/adjustment

☐ Other, specify:

_____

Referral to specialized rehabilitation services

☐ Adaptation to chronic pain ☐ Return to/stay at work

☐ Permanent functional limitations? Specify:

_____

☐ Contraindications for physical activity? Specify:

_____

Pain history

☐ Cessation of work Cessation date Year Month Day

Type of work

Partner: ☐ SAAQ ☐ CSST ☐ Insurance

Date of onset Year Month Day

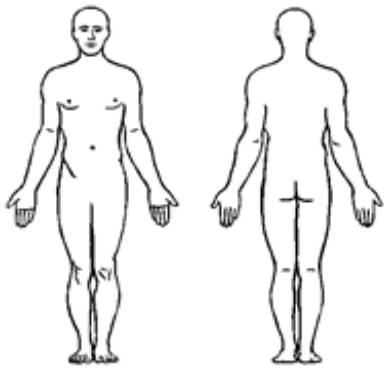
Circumstances

☐ Accident, specify: _____

☐ Surgery, specify: _____

☐ Illness, specify: _____

☐ Other, specify: _____



Location and quality of pain (shade affected area)

☐ Neuropathic ☐ Mixed ☐ Migraine

☐ Nociceptive ☐ Generalized pain

Average intensity over last 7 days: 1 2 3 4 5 6 7 8 9 10

Reason for consultation and diagnostic impression(s)

Patient's name	File no.

Overall physical health	Overall psychological health
☐ Cancer: ☐ Active ☐ Remission ☐ Chronic renal failure (creatinine clearance) _____ ml/min Date: _____ ☐ Diabetes ☐ Cardiovascular disease ☐ Autoimmune disease ☐ Other, specify: _____	☐ Substance abuse and/or use, specify: _____ ☐ Post-traumatic stress, specify: _____ ☐ Depression ☐ Anxiety disorder ☐ Cognitive disorder ☐ Other, specify: _____

Previous interventions and investigations

(Attach report. If unavailable, give date if within last 12 months [Year, Month])

Medical investigations	Report att.	Forth-coming	Date	**Specialized consultations**	Report att.	Forth-coming	Date
X-ray(s)	☐	☐		Pain clinic	☐	☐	
MRI	☐	☐		Specify:			
CT	☐	☐		Other:	☐	☐	
Bone scan	☐	☐			☐	☐	
EMG	☐	☐			☐	☐	
Laboratory:	☐	☐			☐	☐	
Other:	☐	☐		**Therapeutic approaches**			
Medical interventions				Physiotherapy	☐	☐	
Surgery:	☐	☐		Exercise program	☐	☐	
Nerve block:	☐	☐		Interdisciplinary rehabilitation	☐	☐	
Infiltration:	☐	☐		Psychological treatment	☐	☐	
Other:	☐	☐		Other:	☐	☐	

Medication (Attach current list)

Medication tried	Current	Stopped	Names and prescribed dosages of medications tried (please indicate maximum tolerated)	Reason for stopping
☐ NSAIDs/Acetaminopher	☐	☐		
☐ Antidepressants:	☐	☐		
☐ Anticonvulsants:	☐	☐		
☐ Narcotics:	☐	☐		
☐ Other 1:	☐	☐		
☐ Other 2:	☐	☐		
ANTICOAGULANTS:			ANTIPLATELETS (except ASA): ☐ Yes ☐ No	

Patient's pharmacy (and contact information if available):

☐ All relevant reports are attached to this request.

I understand that incomplete requests will be returned. In referring the patient, I undertake to monitor the patient's chronic pain condition during his/her treatment and following the discharge from the pain clinic. If I am a consulting specialist, I undertake to inform the attending/family physician of this request for him/her to ensure an accurate follow-up with the user.

Referring physician phone	**Signature**	**Date**
(Preferred line for physician-to-physician calls)		Year Month Day

REQUEST FOR CONSULTATION – CHRONIC PAIN MANAGEMENT