INITIUM | CENTRE FOR PAIN MEDICINE

Referral Form

PATIENT INFORMATION

Name: ..... PHN: .....

Date of Birth: ..... Phone: .....

Address: ..... Email: .....

..... Patient consents to receive email/text messages ☐

PROVIDER INFORMATION

Referring Provider: ..... MSP: .....

Fax/Email: ..... Phone: .....

Primary Care Provider: .....

REASON FOR REFERRAL

Active ICBC claim: ☐ Active WCB claim: ☐

Location of Pain: .....

Referral Pattern: .....

Duration of Pain: .....

Clinical Summary: .....

TYPE OF ASSESSMENT

Urgent Assessment: ☐ Reason: .....

First Available Pain Physician: ☐

Specific Pain Physician: .....

Sports Medicine: ☐ Physiatry: ☐ Comprehensive Pain Consult: ☐

Interventional Pain Referral: ☐ Specific Procedure: .....

All referrals need to include the specific imaging as listed below:
Peripheral Joint Pain/Arthritis: X-Ray, CT or MRI
Soft Tissue Pathology: Ultrasound or MRI
Radiculopathy: CT, MRI and EMG
Peripheral Mononeuropathy: EMG
Neuropathy: EMG
Cannabis for Pain: Relevant Imaging
At this time, we are unable to see patients with untreated addictions or psychiatric conditions.
We are not able to accept referrals for medications management.

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