Saskatchewan Health Authority

Saskatoon Chronic Pain Service Referral Form

P: 306-655-5978 | F: 306-655-7769
painclinic@saskhealthauthority.ca
Saskatoon City Hospital, Ambulatory Care.
701 Queen St, Saskatoon.

First Name:	
Last Name:	
DoB:	HSN:
Address:	
Town:	
Province:	Postal Code:
Phone:	
Email:	

Insurance:
WCB SGI Third party Sask Health NIHB

The vision of the SHA Chronic Pain Service is to provide a holistic approach to chronic pain management with an opioid stewardship lens, providing direction and support for patients and primary care providers when dealing with complex chronic pain. We provide psychoeducation, mind based strategies, movement therapy, medication assessment (including opioid tapering, opioid consolidation and conversion to buprenorphine) and suggestions as well as minimal interventions such as dry needling, onabotulinum toxin A for chronic migraine, trigger point injections, and peripheral joint injections. If your patient only requires intra-articular injections, nerve blocks or ablations, please refer them directly to this service at the Regina Chronic Pain Clinic (**Fax:** 306-766-7045) or the Saskatoon Interventional Pain Centre https://saskatoonpain.ca.

Patients do not need a primary care provider in order to be seen, but patients are also not retained long term. They are followed for a limited number of visits only, typically over 3 to 12 months, which may include in person visits as well as phone follow ups from various members of the multi-disciplinary team.

Patients are required to complete intake forms prior to being seen – please provide an email address to which intake forms can be sent to the patient.

At an initial visit, patients will be asked to (1) bring all of their medications in their original bottles (2) provide a urine drug screen on registration and (3) dress in loose, comfortable clothing so that their pain area can be properly examined. They are welcome to bring any cushions or props they need to make themselves comfortable, as the initial assessments can take up to 90 minutes of clinician time.

Appointments: Patients will be contacted directly with a date and time of appointment. Late fees and missed appointment fees will apply. If you are late for your appointment you may not be seen and you may be charged a late fee. If you do not cancel within 24 hours for a special procedure or initial assessment, you may be charged a missed appointment fee. Patients who have missed their appointment without notice, will have 6 months from that missed date to rebook. If the patient does not rebook during those 6 months, they will need to be re-referred. Patients who have missed two consecutive appointments will be removed the waitlist.

DRAFT

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Reason for Referral:

MSK pain – (location):

Neuropathic pain:

Abdominal pain: must have GI consult

Pelvic pain: must have gynecology/urology consult

Headaches: must have imaging

Opioid management/concurrent substance use disorder and chronic pain – discussed with patient

Supplementary Information (please attach all relevant labs, imaging, discharge reports and consultations, as well as your own thoughts):

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Cumulative Patient Profile attached: Yes No

Priority if:

More than 100mg/day of morphine equivalent dose (MED) AND one or more of the following: concerning aberrant drug-related behaviors, benzodiazepine use, alcohol consumption

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Referring Provider

Name:

Fax:

Address:

Phone:

Billing number:

Primary Care Provider

Name:

Fax:

Address:

Phone:

DRAFT

I have discussed this referral with the patient, and they consent to the referral as evidenced by their signature below.

Referring Provider Signature: ___________________________ **Date:** ________________________

By providing my signature I understand that use of my personal health information will be in line with *The Health Information Protection Act*, PART IV Limits on Collection, Use and Disclosure of Personal Health Information by Trustees. I understand and that my signature or verbal authorization to this release will allow the Saskatoon Chronic Pain Service to 1.) Obtain any health record(s), including hospital records, physician/social worker/physical therapist office records, diagnostic imaging, pharmaceutical prescription records and patient billing information, or other information relevant to the program.

Patient Signature:__________________________________ **Date:**_____________________________

(if referral is completed virtually primary care provider can initial indicating they have patient's verbal consent)

Patient Email: ____