island health

Pain Clinic Direct to Procedure Program

☐ South Island (RJH) Fax (250) 519-1837 ☐ Central Island Pain Program (NRGH) Fax (250) 739-5989

A. PATIENT INFORMATION		
Last name		
First name		
Date of birth Day Month year		
PHN		
Primary contact number		
Special instructions		
Email (required)		
Street address		
City	Prov	Postal code

B. SEND RESULTS TO	
Referring Physician	
MSP#	☐ This is the Primary Care provider
Clinic name Street Address Phone Fax	STAMP HERE
Family Physician (if different from referring physician)	

C. Procedure Requested (See below for inclusion criteria for each procedure)

☐ Transforaminal Epidural ☐ Medial Branch Block/RFA ☐ Pre-op test injection ☐ Re-referral for a repeat injection

D. Site of Pain & Rationale (brief clinical history)

E. Criteria For Referral Please only select one of the following options (patient must satisfy all criteria to be eligible).

Transforaminal Epidural – for sciatica/leg pain	**Medial Branch Block +/- Radiofrequency Denervation**
☐ Severe decline in function	☐ Age >50 and evidence of facet changes on x-ray within the past 18 months
☐ Lumbar radiculopathy (in a dermatomal distribution) and CT/ MRI after onset of radicular symptoms and within 18 months	☐ Severe decline in function
☐ Failed 1+ therapies (e.g., physiotherapy, medications)	☐ Low back pain or neck pain without radiculopathy
☐ No current anticoagulation	☐ Failed 1+ therapies (e.g., physiotherapy, medications)
Re-referral for repeat single injection	**Pre-op test injection**
☐ Patient does not require a repeat consult	☐ Requesting specific injection to evaluate outcome before a surgical procedure
☐ Previous patient of I**sland Health pain clinic**	☐ No current anticoagulation
☐ Patient reports last treatment effective	
☐ The last patient visit was >12 months ago	

F. Prior & Future Injections

☐ Yes ☐ No Prior injection? If **yes**, include most recent injection & applicable documents (within the last year) _____

☐ Yes ☐ No Does patient have a scheduled injection with medical imaging or other pain service? If **yes**, date: _____

G. Criteria

PC-DTP is a referral program that streamlines **requests for one time injections** at Island health's Pain Clinic. The goal is to receive referral and schedule an injection within 8 weeks. The patient will follow-up with the referring provider ONLY. The pain physician will not follow-up unless requested due to complications.

1. **Referrals must be non-emergent (> 3 weeks).** Requests for emergent procedures must be arranged through contact with the pain specialist by calling the Island pain clinic RJH 250-519-1836 or NRGH 250-739-5978
2. Candidates for PC-DTP **must not** have had an injection in the same pain area with any other service in the last 3 months (e.g., Radiology, Helmcken, Rebalance, Bowler's, Myo Clinic, Intervention Plus and the Nanaimo Pain Clinic)
3. **To receive ongoing interventional care, referrals should continue to be sent via the routine "Regional Interdisciplinary Chronic Pain Program Referral" form.**

Clinic to acknowledge receipt of referral by faxing ☐Acceptance letter or ☐ Incomplete/returned letter within 21 business days

South Island Pain Program (RJH) Phone: 250 519 1836 **Central Island Pain Program (NRGH) Phone: 250 739 5978**

island health

Pain Clinic Direct to Procedure Trial Program

☐ South Island (RJH) Fax (250) 519-1837 ☐ Central Island Pain Program (NRGH) Fax (250) 739-5989

H. Medication PLEASE ATTACH Electronic Medication history or fill out below			
☐ No Medication			
Anticoagulation/antiplatelet	☐ Yes	☐ No	Drug and indication:
List all other medications that are not listed above, or attach list:			
Allergies ☐Yes ☐No If yes, include details			

I. Physical exam
In office physical completed ☐Yes ☐No
Height cm:_____ Weight kg:_____ BMI:_____

J. Medical Information PLEASE ATTACH Electronic Medication history or fill out below			
Heart disease	☐ Yes	☐ No	If yes, include details
Pacemaker/defibrillator	☐ Yes	☐ No	If yes, include details
Anxiety/Depression	☐ Yes	☐ No	If yes, include details
Bleeding disorder	☐ Yes	☐ No	If yes, include details
Cancer	☐ Yes	☐ No	If yes, include details
Previous spine surgery	☐ Yes	☐ No	If yes, include details
Other Chronic Medical Condition not listed above:			
Surgical History (include dates):			

Required Medical Information

The following **MUST** be included with the DTP referral form or the referral will be returned and closed:

1. As per College of Physicians and Surgeons of BC, referrals must include the following:
   a. A letter providing clinical history and reason for referral including specific focal location of the pain
   b. List of current medications
   c. List of patient's medical conditions
2. All lab results and documents indicated in Sections **E, F, H and I must be included with referral or the referral will be returned**.

Pain Clinic Direct to Procedure Trial Program

☐ South Island (RJH) Fax (250) 519-1837 ☐ Central Island Pain Program (NRGH) Fax (250) 739-5989

RJH - DTP Timelines

DTP acknowledges, accepts or rejects referrals in the following manner and timelines:

1. **Accepted referrals will be acknowledged by Acceptance Letter within 21 business days.** If you do not receive an Acceptance Letter within 21 business days, please notify the Island Health pain clinic **by fax**.
2. Incomplete referrals, or referrals lacking requested results / documents, will be returned and considered closed. **If a referral is returned, you will receive notification via Rejection Letter within 21 business days.** If a referral is rejected, a **NEW REFERRAL** will need to be submitted to, along with the missing documents.
3. If you have any questions regarding the completion of the referral form, contact the RJH Pain Clinic Program at 250-519-1836 or the Central Island Pain Program (NRGH) Office at 250-739-5978.

Suitable for Direct to Procedure:

1. Patient meets above criteria for listed injection options (Reason for Referral Section E)
2. Patient competent and capable of consent
3. Absence of major medical and psychiatric illness requiring assessment through the routine "Regional Interdisciplinary Chronic Pain Program Referral" form.
4. Patients on dual antiplatelets (requiring epidural), cardiac stents less than 6 months, stroke/MI less than 3 months are not candidates for safe referral through the PC-DTP.
5. Patients will not have a full and complete pain assessment through the PC-DTP. Kindly ensure that your patient is aware of this. If you would like your patient to have a full assessment, please complete the routine "Regional Interdisciplinary Chronic Pain Program Referral" form.