Patient Label or
Patient Name:________________________________
PHN:________________________________
Address: ________________________________
____
Phone:________________________________

Transitional Pain Service Referral Form

7th Floor, Diamond Health Centre 12th Avenue, Vancouver, BC
(Phone) 604-675-3653 (Fax) 604-675-3659

Referred by: ☐ POPS ☐ CPAS ☐ Surgical Services ☐Family Physician or Nurse Practitioner (Name: ___________________________)

Eligibility Criteria (all criteria must be met)		
☐ Have a 'prescribing care provider' (Family Practitioner) to provide follow up care	☐ Ready and agree to participate (includes personal goal setting and wish to decrease opioid use)	☐ Had Surgery or Trauma Admission at UBC/VGH/LGH in past 3 months

Surgery Type	**Reason(s) for Referral** *(May check more than one box)*
☐ Cardiac Surgery ☐ Dental Surgery ☐ General Gynecology ☐ General Surgery ☐ Gynecology Oncology ☐ Neurosurgery ☐ Ophthalmology Surgery ☐ Oral Facial Maxillofacial Surgery ☐ Ortho Athletics ☐ Ortho Reconstructive ☐ Ortho Trauma ☐ Otolaryngology ☐ Plastic Surgery ☐ Spine Surgery ☐ Thoracic Surgery ☐ Urology Surgery ☐ Vascular Surgery ☐ Non-surgical ☐ Transplant	☐ Reports struggling with post-surgical pain ☐ Reports more post-surgical pain than is typical ☐ Surgical pain does not appear to be resolving ☐ Difficulty weaning off opioids after surgery ☐ Depressed, anxious and/ or significantly distressed secondary to post-surgical pain ☐ Concern about possible opioid misuse **COMMENT: What treatment do you want TPC to focus?**

SURGEON/MRP: ____
Surgery: ____
Site of Surgery: ☐ VGH/UBC ☐ LGH ☐ Other: ________________________________
Date of Surgery/Estimated Date: ________________________ Estimated Discharge Date: ________________________

REFERRING PROVIDER INFORMATION: Date of Referral: _____________ MD/ NP Name: ______________________________

*The TPC is **NOT** a Rapid Access clinic and cannot prescribe opioids or provide client services until we have assessed your client. We aim to see clients within two weeks. Please be sure arrangements to support your client are made for this timeframe, either through the client's GP or nurse practitioner, or directly from surgical services*

Please fax to 604-675-3659. Thank you.

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For TPC Internal Use: ☐ Accepted Declined: ☐ client declines ☐ no recent surgery or trauma ☐chronic pain clinic indicated ☐ no prescriber
Date: ________________________________ Signature:____

☐ Entered in REDCap Initial: ________