PAINSCAPE - STANDARDIZED CASE MANAGEMENT REFERRAL

Dr. Petrus Retief INC - Pain & Rehabilitation Physician - Fax:(604) 914 2009

Patient Full Name: _____ DOB: D ☐ /M ☐ /Y ☐ PHN#: _____

Phone #: (Mobile)_____(Home)_____Email:_____

(Note: Please notify patient that by providing a mobile phone number and email address, they consent to receiving email and text messages)

Referring Physician: _____MSP#: _____

Phone: _____Fax: _____Email: _____

Family Physician: *(if not the same as above)*_____

Office Phone: _____ Fax: _____

Referral Diagnosis & Location: _____

Secondary Diagnosis **or** Complicating Factor: _____

Condensed History & Reason for referral: Active claim ICBC ☐ or WCB ☐ No claim ☐

Reason for referral:

Other Complicating Factors:

Biological: _____Psychological: _____

Social: _____Activity Level: ☐ Low ☐ Medium ☐ High

Duration of Symptoms: Options ☐ Initial Incident (if any): _____

The following type of pain is suspected (please tick relevant boxes)

☐ Mechanical Pain	☐ Neuropathic Pain	☐ Mixed Pain	☐ Central Sensitization Pain

Previous Consultations, Investigations or Treatments:

Type	Date / Period	By Whom	Investigation/Opinion/Treatment	Report Included	
☐ Investigation				☐ Yes	☐ No
☐ Consultation				☐ Yes	☐ No
☐ Physical Therapy				☐ Yes	☐ No
☐ Psychotherapy				☐ Yes	☐ No
☐ Interventions				☐ Yes	☐ No
☐ Other:				☐ Yes	☐ No

Medication for Pain Management:

1. _____ 2. _____ 3. _____

Anti-Coagulants:

☐ No	☐ Yes – Name Options ☐ for Condition: Options ☐

Service Requested: (tick relevant boxes & specify if needed)

☐ Single Service *(Intervention only requested)*	Specify: Options ☐
☐ Team Services *(Allied health also requested)*	Service 1: Options ☐
	Service 2: Options ☐
	Other:

Triage: (tick all relevant)

Type & Urgency of Referral	
☐ First Referral	☐ Repeat Referral
☐ Urgent (must be seen within 14 days)	☐ Non-Urgent (book first available appointment)
☐ Book with any Physician	☐ Book with specific Physician - Specify: Options ☐