Santé et Services sociaux Québec

DT9248

REQUEST FOR CONSULTATION – CHRONIC PAIN MANAGEMENT

Patient Informations

First Name and Family Name (at birth)

Sex ☐ M ☐ F | Date of birth Year Month Day

Medicare number | File Number (internal use only)

Address (number, street)

City | Postal Code

Area code Telephone (home) | Area code Telephone (other)

Name of a relative or friend | Area code Telephone

Patient's email address

Step 1: Reason for the request (check a single box in either the "Pain Clinic" or "Rehabilitation Centre" section)

Pain Clinic

Priority Codes Legend (PC)

B ≤ 10 DAYS
C ≤ 28 DAYS
D ≤ 3 MONTHS
E ≤ 12 MONTHS

☐ Diagnostic opinion
☐ Therapeutic recommendations
☐ Nerve block only

Rehabilitation Centre

Mandatory criteria for a referral:

- Functional impacts in several domains of life
- Need for an interdisciplinary team
- Patient's availability up to few times a week for rehabilitation
- Patient's willingness to engage in rehabilitation (self-management)

☐ Chronic pain adaptation/ rehabilitation program
☐ Returning to or remaining at work

Step 2: Clinical Profile - Diagnoses (check only one box in the following sections)

Approximate date of onset of pain Year Month

Triggering event ☐ No ☐ Yes - If yes, please specify: _____

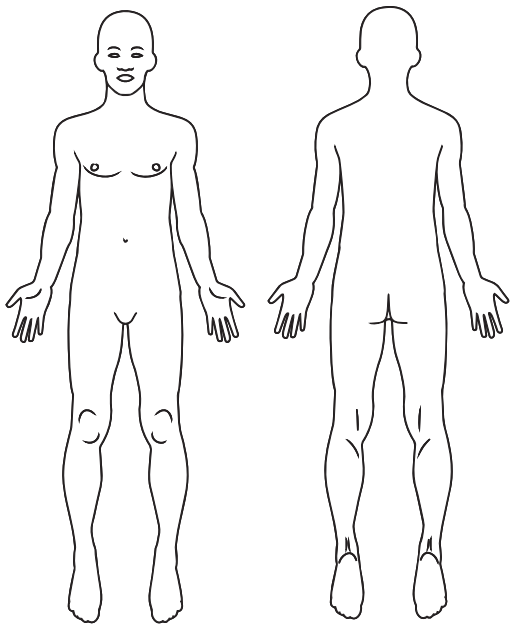
Physiotherapy treatment in progress: ☐ Yes ☐ No

☐ Cervicalgia/cervicobrachialgia (prerequisite: X-ray or CT or MRI)	E
☐ Back pain (prerequisite: X-ray or CT or MRI)	E
☐ Low back pain/lumbosciatica (prerequisite: CT or MRI)	E
☐ Spinal stenosis (prerequisite: CT or MRI)	E
☐ Chronic musculoskeletal pain (prerequisite: X-ray or CT or MRI)	E
☐ Chronic widespread pain (depending on availability of services) e.g., fibromyalgia	E
☐ Chronic visceral pain (abdominal and/or pelvic) (prerequisite: related specialty report)	E
☐ Chronic neuropathic pain (EMG report if relevant)	E
☐ Chronic headache or orofacial pain (prerequisite: related specialty report e.g., neurology)	E
☐ Chronic post-surgical pain	E
☐ Chronic post-traumatic pain	E
☐ Pain related to an active cancer	C
☐ Complex regional pain syndrome	E
☐ Indicate whether the patient is treated or waiting to be treated in a rehabilitation centre	
☐ Check if edema is detectable by referring MD and diagnosis ≤ 6 months	D

For the required prerequisite, please indicate whether:

☐ Available on the Quebec Health Record (QHR) (DSQ) or
☐ Attached to the present request

Location of pain. Shade affected area(s):



Patient's name	File no.

Step 3: Additional details

Please check if the pain is associated to a condition below:	PC		PC
☐ Palliative care	C	☐ Degenerative and rapidly progressive neurological disease	D
☐ Loss of autonomy associated with pain in elderly pt ≥ 85 yrs	D	☐ Osteoporosis with fractures in the last 3 months	D
☐ Systemic manifestation of autoimmune disease with positive paraclinical lab tests in the last 3 months	D	☐ Pregnant woman	C

Diagnostic impression and required clinical information

_____

_____

Current paying agent in the history of the painful condition:
☐ SAAQ ☐ CNESST ☐ Private Insurance ☐ Other

Start date Year ____ Month ____ Day ____

Please check the items below that apply to your patient (12 modulators) and attach relevant documents

- ☐ Severe non-psychiatric comorbidity impacting drug metabolism (e.g., renal, hepatic, pulmonary, cardiac failure, etc.)
- ☐ Comorbidity(ies) associated with obesity impacting the level of physical deconditioning (e.g., sleep apnea, diabetes)
- ☐ Axis 1 psychiatric comorbidity
- ☐ More than one pain condition (excluding fibromyalgia)
- ☐ Pain arising from trauma
- ☐ Failure of ≥ 3 classes of analgesic agents (indicate agent, maximum dose titrated, and cause(s) of discontinuation)
  - •
  - •
  - •
- ☐ Frequent medical consultations for poorly controlled pain (consider all settings)

Absenteeism from school or work related to the painful condition
☐ < 12 months or ☐ ≥ 12 months

- ☐ Maintaining work or school is precarious due to pain
- ☐ Functional impairment in activities of daily living and domestic life - reduced mobility
- ☐ Marginality or precarious social situation
- ☐ Patient accepting substitution therapy for a comorbid substance use disorder or seeking opioid reduction

Step 4: Consultation request for nerve block only according to the services available

(Prerequisite : medical assessment report with documentation of attempted conservative treatments)

☐ Spinal block (prerequisite: CT or MRI)

☐ Facet ☐ Foraminal ☐ Inter-laminar ☐ Caudal ☐ Sacro-iliac

Please specify level(s) and side(s) if relevant or enter "not applicable": _____

☐ Intra-articular block (prerequisite: CT or MRI)

Specify the joint to be the infiltrated: _____

☐ Other type of block, please specify: _____

☐ Block to be chosen by the consulting MD

Line reserved for the exclusive use of designated partner pain clinics of a CECP (CEGDC) :

☐ Tertiary level technical platform (please specify the desired block): _____ **C**

Does the patient have allergies? (e.g., Iodine, antibiotics)	☐ Yes ☐ No	If yes, specify:
Is the patient taking an anticoagulant?	☐ Yes ☐ No	If so, can the anticoagulant be temporarily stopped for the procedure? ☐ Yes ☐ No
Does the patient have special needs? e.g., interpreter, adapted transport, contraindication to physical activity, other:	☐ Yes ☐ No	If yes, specify:

Patient's name	File no.

Step 5: Referrer information

Name	License number	Nominative referral (if required):
Address	Email address	
Area code Telephone	Area code Fax	

Signature		**Date**	Year Month Day

If you are a physician practicing in a pain clinic that is a partner of a CECP, please specify it here and indicate the territory of your RUISSS (Priority code: C):

Information on the family physician or on the professional providing ongoing care

Name	License number	☐ **Same as referring**	☐ Patient without family doctor or professional providing ongoing care
Address			

Name and address of GMF, GMF-U or clinic where patient is registered

Change in priority at the discretion of the responding physician in the pain clinic.

Please indicate whether you agree to your request being redirected if there is a pain clinic in your patient's area: ☐ Yes ☐ No

☐ Any relevant reports are attached to this request. I understand that an incomplete request will be returned. In referring the patient, I undertake to follow up their chronic pain condition during treatment and following discharge from the clinic. If I am a consultant specialist, I undertake to inform the treating/family doctor of this referral request, so that the treating/family doctor can follow up with the patient.

Appendix 1: Support methods and teleservices for professionals, MSSS guidelines, IMAGe info centre, recommendations on anticoagulation during technical interventions, clinical alerts to direct the patient to the emergency room, list of diagnoses for which a consultation in a pain clinic is not indicated or for which there are specialised resources (drug addiction problem, medico-legal expertise, somatoform disorder)