Persistent Pain Program

Berwick Persistent Pain Clinic
Western Kings Memorial Health Centre Berwick, NS B0P 1E0
ph 902-538-7102 fax 902-538-7996

Persistent Pain Program REFERRAL

Name: ____ **DOB (Y/M/D):** ______________________

Health Card #: _________________________ **Family Doctor:** ______________________________

Address: ______________________________ **Phone: (H)** _______________ **(C)** _______________

______________________________ **Email:** ______________________________________

☐ **Consent to use e-mail knowing that unencrypted e-mail is not a secure form of communication**

Dx / Reason for Referral: ____

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Relevant Past History: ____

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Relevant medical investigations completed (ex: X- rays, CT scan, MRI, Ultrasound):

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Other current treatments for pain:____

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Is the patient ready and willing to make attempts to self-manage pain through learning new non-medical based approaches, and setting appropriate behavior change goals?

Yes / No / Unsure

Is the patient appropriate for participating in a group program (10 weekly afternoon sessions)?

Yes/No/Unsure

Additional comments: ____

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Professional/Referral Source: ________________________ Date **of Referral:** ___________________

PLEASE FAX COMPLETED FORM TO 902-538-7996