nova scotia health authority

PAIN SELF-MANAGEMENT PROGRAM REFERRAL

Patient Name _____
Date of Birth _____
Address _____
_____
Phone No. (H) _____
Phone No. (C) _____
MRN _____
HCN _____

Fax completed referral to your location of interest:

□ Halifax/Dartmouth Fax: (902) 473-4126 *Patient must contact program (902) 473-5471 to schedule assessment
□ Windsor Fax: (902) 792-2196 *Program coordinator will contact patient once referral received

□ **PSMP Brochure Provided to Patient**

Patient Diagnosis:

_____

_____

_____

Does the Patient have a history of mental illness, head injury or cognitive dysfunction that may impact on their ability to learn in a group setting?

☐ No
☐ Yes Explain _____

Does the patient have any medical conditions or social circumstances that may impact their ability to attend or participate in the program? (e.g. visual or hearing impairment, financial or transportation challenges, medical instability, communication challenges, etc)

_____

_____

_____

_____

Please ensure the patient understands and commits to the following goals:
a) Regular attendance
b) Willing to participate in the movement component of the program
c) Willing to challenge current activity styles and beliefs
d) Willing to begin process of implementing new strategies learned in the program

Referral Source _____ Date _____
(PLEASE PRINT)