

Transitional Pain Clinic Referral Form

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

The TPC offers short-term interdisciplinary outpatient pain management services before and after surgery or trauma.

*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 one month. 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.*

Incomplete referral forms <u>will not</u> be processed and will be returned to the referring provider. Please print clearly.	
Pre-op Eligibility Criteria	Post-op Eligibility Criteria
<input type="checkbox"/> Pain or concerns are related to planned surgery AND <input type="checkbox"/> Has a planned surgery at any VCH hospital AND <input type="checkbox"/> Cognitively able to participate and no severe psychiatric instability.	<input type="checkbox"/> Pain is related to recent surgery or trauma AND <input type="checkbox"/> Had surgery or trauma services at any VCH hospital in the past 4 months AND <input type="checkbox"/> Cognitively able to participate and no severe psychiatric instability.
Pre-op Reason(s) for Referral	Post-op Reason(s) for Referral
<input type="checkbox"/> Medication weaning or medication review <input type="checkbox"/> Difficulties managing pre-surgery anxiety <input type="checkbox"/> Difficulties with daily function due to pain <input type="checkbox"/> Pain-related education support <input type="checkbox"/> Optimize pre-surgical physical and mental health <input type="checkbox"/> Other:	<input type="checkbox"/> Reports struggling with post-surgical/trauma pain <input type="checkbox"/> Reports more post-surgical pain than is typical <input type="checkbox"/> Surgical/trauma pain does not appear to be resolving <input type="checkbox"/> Difficulty weaning off opioids after surgery/trauma <input type="checkbox"/> Depressed, anxious and/ or significantly distressed secondary to post-surgical/trauma pain <input type="checkbox"/> Concern about possible opioid use disorder <input type="checkbox"/> Other:
Surgery/Trauma Details	
Surgeon/Provider: _____ Date of Surgery / Estimated Date of Surgery: _____ Surgery/Trauma Details: _____ Discharge Date (if known): _____	
Client Information	
Client's email address: _____ Client's phone number: _____ Primary Care Provider (PCP) Name: _____ PCP Phone Number: _____ Interpreter required? Y <input type="checkbox"/> / N <input type="checkbox"/> Language: _____	
Referring Provider Information	
Name: _____ Date of Referral: _____ Referral Source: CPAS <input type="checkbox"/> POPS <input type="checkbox"/> Surgical Services <input type="checkbox"/> Pre-Admission Clinic <input type="checkbox"/> PCP <input type="checkbox"/> Other: _____	
Have you discussed this referral with the client? <input type="checkbox"/> YES <input type="checkbox"/> NO	

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

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