Salem Anaesthesia Pain Clinic. Unit 100, 6638 152A Street, Surrey, BC, V3S 7J1
Phone-7786286600, 7786952888. Fax-7786952898. Email- salem.painclinic@gmail.com

**Referral Checklist Form**: Must accompany referral for pain consultation

Date of referral (dd/mm/yyyy):_____

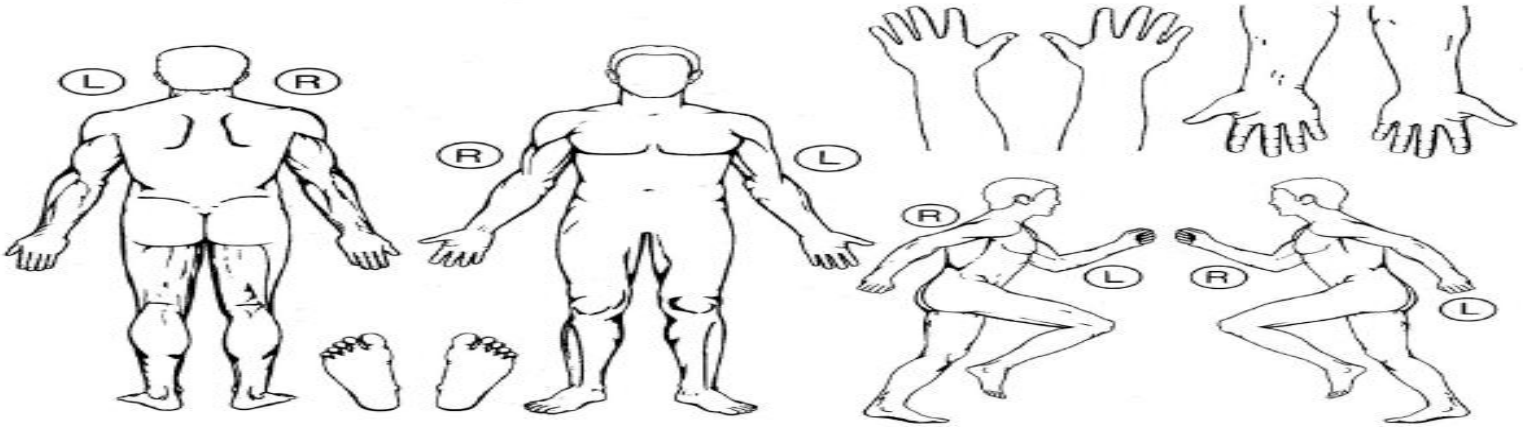
Patient's name:_____ **[]** New patient. **[]** Repeat referral

Date of birth (dd/mm/yyyy):_____ PHN:_____

Address:_____

Cell phone:_____Home phone:_____Email:_____

Pain sites:_____Radiculopathy sites:_____




Pain description (dull, sharp, burning, stabbing, etc):_____Duration (months):_____

Activities of daily living: No issue **[].** Cope adequately **[].** Struggle to cope **[].** Need some assist **[].** Need full assist **[].**

Previous pain interventions:_____

Current pain medications:_____

Other medications:_____

Allergies/sensitivities:_____

Tobbaco smoking, per day:_____ Cannabis use, per day:_____

Alcohol use, per day:_____ Substance use, per day:_____

Psychologic issue:_____ Psychiatric medications:_____

Living condition:_____ Occupation:_____

Medical history:_____

Trauma history:_____

Surgical history:_____

Relevant specialist consult reports attached: Yes_____ No_____

Recent radiology reports of pain sites attached (within 2yrs): Yes_____ No_____

Referring clinician:_____MSP #:_____

Clinician's signature:_____ Fax:_____Phone_____