Vancouver CoastalHealth

Patient Label

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 will not be processed and will be returned to the referring provider. Please print clearly.**

Pre-op Eligibility Criteria	Post-op Eligibility Criteria
☐ Pain or concerns are related to planned surgery AND ☐ Has a planned surgery at any VCH hospital AND ☐ Cognitively able to participate and no severe psychiatric instability.	☐ Pain is related to recent surgery or trauma AND ☐ Had surgery or trauma services at any VCH hospital in the past 4 months AND ☐ Cognitively able to participate and no severe psychiatric instability.
Pre-op Reason(s) for Referral	**Post-op Reason(s) for Referral**
☐ Medication weaning or medication review ☐ Difficulties managing pre-surgery anxiety ☐ Difficulties with daily function due to pain ☐ Pain-related education support ☐ Optimize pre-surgical physical and mental health ☐ Other:	☐ Reports struggling with post-surgical/trauma pain ☐ Reports more post-surgical pain than is typical ☐ Surgical/trauma pain does not appear to be resolving ☐ Difficulty weaning off opioids after surgery/trauma ☐ Depressed, anxious and/ or significantly distressed secondary to post-surgical/trauma pain ☐ Concern about possible opioid use disorder ☐ 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 ☐ / N ☐ Language: _____

Referring Provider Information

Name: _____ Date of Referral: _____

Referral Source: CPAS☐ POPS☐ Surgical Services☐ Pre-Admission Clinic☐ PCP☐ Other:_____

Have you discussed this referral with the client? ☐ YES ☐ NO

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