THE University of Vermont MEDICAL CENTER

MRN

Name

DOB

COMPREHENSIVE PAIN PROGRAM

Thank you for your referral to the Comprehensive Pain Program (CPP). We look forward to coordinating your patient's care with you.

CPP provides a 12 and 16-week team-based, transdisciplinary approach designed to help individuals suffering from chronic pain achieve optimal comfort and function. The majority of individuals referred to us engage in a group program, which incorporates education, self-reflection, and mindfulness. During the program, participants have access to a number of integrative and non- traditional therapies.

Patients seen at CPP for participation in a group offering should meet the following criteria:

- Have pain of at least three months duration interfering with a significant part of their life – home, social connection, vocation;
- Have completed medical/surgical evaluation to define an etiology for pain;
- Have engaged in other therapies prior to referral;
- Are psychologically stable;
- Are not engaged in active substance use;
- Are motivated to engage in the full offerings of the program;
- Are under the care of a designated primary care clinician.

Patients who are not candidates for group participation may be seen in individual consultation. While we can make recommendations and maintain a collaborative effort with you, we are not able to assume ongoing management of their medications or their long-term care.

***Before we can schedule your patient to be seen at CPP, we ask that you provide us* with the following information. Once we have this information, we would be happy to schedule an evaluation for your patient with one of our providers.**

Patient Name_____**DOB**_____

Are you the patient's primary care provider? ☐Yes ☐ No--Specialty:_____

If not, who is the primary care provider? _____

If you are not the patient's primary care provider, please notify that individual of your referral.

118 Tilley Drive, South Burlington, VT 05403 Phone: 802-847-5550 Fax: 802-847-3646

***Please attach recent notes or a description of the patient's care related to their pain condition, their problem list, current medication list, and insurance information.**

Please provide a brief summary of the patient's history and clinical course.

****Please fax completed form and pertinent notes/imaging results to 802-847-3646*****

Provider Signature

Date/Time

Print Provider Name