BeWell Medical Clinic

Trigger Point Injection (TPI) Referral

Fax: 604-770-0165 | Email: info@bewellmedical.ca | Phone: 604-770-0164

Please complete all sections and fax or email this form with supporting documents (Section 6). Incomplete referrals may delay booking. Fields marked * are required.

Date of referral* (yyyy-mm-dd)

1. PATIENT INFORMATION

Last name*	First name*	Date of birth* (yyyy-mm-dd)	Sex / gender

Personal Health Number (PHN)*	Phone*	Email

Mailing address	City	Postal code

Preferred language

☐ Interpreter needed

Can we contact the patient directly to book? ○ Yes ○ No

2. REFERRAL DETAILS

Physician requested: ○ Dr. Amini ○ Dr. Tabassi ○ Dr. Baradaran ○ Dr. Sharma ○ First available physician

Referral type: ○ New patient ○ Re-referral

Funding: ☐ MSP ☐ WorkSafeBC ☐ ICBC ☐ Private / other Claim #

Legal action pending related to the pain? ○ Yes ○ No

3. PAIN HISTORY

Location of pain* (check all that apply):

☐ Neck ☐ Shoulder / upper back ☐ Lower back ☐ Arm ☐ Leg / hip ☐ Tension headache

Side: ○ Left ○ Right ○ Bilateral Other:

Duration of pain*	Pain severity (0-10)	Suspected diagnosis (e.g. myofascial pain, fibromyalgia)

Pain description / reason for referral* (onset, mechanism of injury, aggravating factors, functional impact)

Treatments already tried* (check all that apply):

☐ Analgesics / NSAIDs ☐ Physiotherapy ☐ Massage ☐ Chiropractic ☐ Acupuncture

☐ Exercise / kinesiology ☐ Previous TPI ☐ Other injections Details / response:

Relevant imaging / investigations (type, date, findings - attach reports)

Clear form

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4. MEDICAL HISTORY AND SAFETY SCREENING

Relevant medical history	Current medications (or attach medication list)

On anticoagulant or antiplatelet medication?	◯ Yes	◯ No	◯ Unknown	If yes to any, please specify:
Bleeding disorder?	◯ Yes	◯ No	◯ Unknown	
Pregnant or possibly pregnant?	◯ Yes	◯ No	◯ Unknown	
Skin infection at or near injection site?	◯ Yes	◯ No	◯ Unknown	
Significant communicable disease?	◯ Yes	◯ No	◯ Unknown	
Does the patient have needle phobia?	◯ Yes	◯ No	◯ Unknown	
Is the patient aware of TPI treatment?	◯ Yes	◯ No	◯ Unknown	

Allergies (including local anaesthetics, latex, adhesives)*	☐ No known allergies (NKA)

5. REFERRING PROVIDER

Referring physician / NP name*	MSP practitioner number*	Clinic name

Clinic address	Phone*	Fax*

Email	Signature	Date (yyyy-mm-dd)

6. SUPPORTING DOCUMENTS

Documents included with this referral (check all that apply):

☐ Imaging reports ☐ Consult / specialist notes ☐ Physio / therapy notes ☐ Medication list

☐ Lab results ☐ Photos / images ☐ WorkSafeBC / ICBC forms Other:

List of attached files (names):

How to include files

Attach a file

Option A - Attach to this PDF: click the 'Attach a file' button (Adobe Acrobat / Adobe Reader), or use the paperclip (Attachments) panel. Repeat for each file, save the PDF, then email it to info@bewellmedical.ca.
Option B - Fax: fax this form followed by the supporting documents to 604-770-0165.
Option C - EMR: print this form with your EMR documents and fax them together.
Please do not send original imaging films or CDs. Questions? Call 604-770-0164 (Mon-Fri, 9 AM - 5 PM).