

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY, EUROPE REGIONAL MEDICAL COMMAND
CMR 442
APO AE 09042-1030

MCEU-DC

25 MAR 03

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: ERMC Command Policy Letter 25, Pain Management Referral Policy

1. The Pain Management Clinic at LRMC is a single provider clinic supporting the European Regional Medical Command area of responsibility. It is of utmost importance to ensure referrals to this limited resource are appropriate.
2. Consults to the Pain Management Clinic will be entered electronically to LSL-Anesthesiology Pain Clinic and will be reviewed within 24 hours by the pain management specialist. The referral will be accepted or returned based on its appropriateness. The referring provider should inform the patient to contact the Pain Management Clinic after 24 hours to schedule an appointment. If the referral is returned to the referring provider, the LRMC Pain Management Clinic will inform the patient when he or she calls for an appointment why the referral was returned and also what action the patient should take.
3. Appropriate referral criteria:
 - a. Emergency Referrals – there are no true pain management emergencies
 - b. ASAP (72 Hours) Referrals – required referring physician to contact LRMC Pain Management Specialist.
 - (1) Post-dural puncture headache
 - (2) Acute herpes zoster for sympathetic block
 - (3) Acute radiculopathy without red flags in which greater four weeks of conservative therapy has failed. Oral corticosteroids should be tried first.
 - (4) Suspected acute RSD (CRPS I).
 - (5) MEB Patients (Pain Management Specialist will be a consultant to the MEB providing an addendum to the packet)
 - (6) In-patient consults
 - (7) OEF patients
 - (8) Cancer pain patients
 - (9) Direct provider referrals after phone consultation if warranted
 - c. Routine Referrals
 - (1) Chronic axial and radicular spine related pain after patients have failed a trial of oral analgesics (NSAIDs and/or TCAs) and physical therapy and have no

neurological red flags. Neurosurgical evaluation for chronic radicular pain prior to referral is preferred as well as an MRI. Patients in this category requiring chronic opioid analgesics to function will also be accepted.

(2) Chronic testicular pain must first be seen by a urologist.

(3) Chronic abdominal pain must first be evaluated by general surgery and/or gastroenterology.

(4) Chronic female pelvic pain must first be evaluated by gynecology.

(5) Chronic inguinal pain must first be evaluated by general surgery

(6) Chronic head ache patients must first be evaluated by neurology and should only be referred to the Pain Management Clinic if they require opioids for control of pain or have a suspected occipital or cervicogenic source of pain.

(7) Chronic knee, hip, ankle or foot pain must first be evaluated by orthopedics, physical medicine, or podiatry.

(8) Rheumatologic disorders must first be evaluated by rheumatology or internal medicine.

(9) Fibromyalgia and/or myofascial pain syndrome patients who fail a trial of exercise and TCAs.

4. The proponent for this policy is the Chief, Clinical Operations at DSN 371-3303.



ELDER GRANGER
Brigadier General, USA
Commanding

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