Chronic Pain Management Referral Form

Please complete and Fax this form to 1 (437) 703-5128

Niagara Falls ☐ St. Catharines ☐ Welland ☐ Hamilton ☐ Oakville ☐ Mississauga ☐ Kitchener ☐ Orangeville ☐ Windsor ☐

Patient Info

*Health Card _____ *VC _____ *Date of Birth _____

*Name _____ *Cell _____ Alt. Tel. _____

*Address _____ City _____ Postal Code _____

Province _____ Does this patient have 3rd party coverage? If yes, please provide insurance provider _____

Is this patient a: New Patient ☐ Re-referral ☐

Reasons for Referral

History of Drug/Alcohol abuse or addiction? Yes ☐ No ☐

1. Pain History

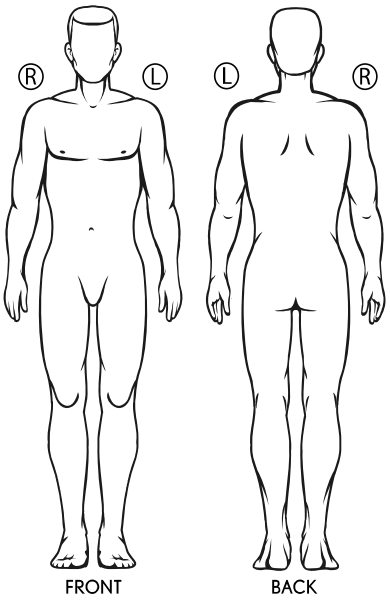
2. Physical Examination Findings

3. Investigations and Consultations

4. Previous Pain Related Procedures

5. Diagnosis

Check Areas of Pain Treatment



Referred For

- ☐ General Pain Management
- ☐ Referral Post MVA
- ☐ Medical Marijuana Consultation
- ☐ W.S.I.B

Specific Intervention

- ☐ Platelet Rich Plasma
- ☐ Epidural
- ☐ Botox
- ☐ Nerve Block

Other _____

Please check applicable Items

- ☐ Neck Pain
- ☐ Back Pain
- ☐ CRPS/RSD
- ☐ MVA-Related
- ☐ Fibromyalgia
- ☐ Headache
- ☐ Neuropathic Pain
- ☐ Radiculopathy
- ☐ Persistent Post-Surgical Pain

Other _____

Physician Info

*CPSO # _____ *Billing# _____

*Dr. _____ *Tel _____ *Fax _____

*Address _____ *City _____ *Postal Code _____

Province _____ Are you the patient's Family Physician or Most Responsible Physician (MRP)? Yes ☐ No ☐

Do you belong to a: FHO ☐ FHT ☐ FHG ☐ CCM ☐ Other: _____

Please provide us with the latest:

☐ Past medical history ☐ Latest MRI, CT, X-ray, NCS/EMG ☐ Medications ☐ All relevant consultation or prior treatment reports

As the most responsible physician, by signing the below, I agree to continue the patient's prescription and primary care once the patient is stable and under the care by PCC.

Please complete and Fax this form to 1 (437) 703-5128

_____ Physician Signature

_____ Date