Pain Care Clinics

Chronic Pain Management Referral Form

Please complete and fax in this form

FAX: 1 (888) 533-6512 | PHONE: 1 (844) 622-7246

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

Patient Info

Health Card No. _____ VC _____ Date of Birth _____

Full Name _____ Main Tel./Mobile _____ Alt. Tel. _____

Address _____ City _____ Postal Code _____

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

This patient is a: ☐ New Patient ☐ Re-referral ☐ WSIB/MVA

History of drug/alcohol abuse or addiction? ☐ Yes ☐ No

Physician Info

CPSO # _____ Billing # _____

Dr./NP _____ 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 _____

Reasons for Referral

Diagnosis / Comments:

To expedite the referral, please provide:

- Patient's Medical History
- Diagnostic and/or consultation reports
- Current Medications

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

_____ Physician Signature

_____ Date