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

Caledonia	Hamilton	Kitchener	Mississauga	Niagara Falls	Oakville	Orangeville	St. Catherines	Windsor	Windsor County
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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:

*** Referral for chronic non-cancer pain ***

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