PAIN CARE CLINICS

Chronic Pain Management Referral Form

Halifax Clinic

Please complete and fax in this form

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

Patient Info

Health Card No. _____ Expiry Date: _____ 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 ☐ WCB/MVA

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

Physician Info

License/Provider Number _____ Billing # _____

Dr./NP _____ Tel _____ Fax _____

Address _____ City _____ Postal Code _____

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

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.

_____ Healthcare Provider Signature

_____ Date