PCC PAIN CARE CLINICS

Hamilton Referral Application

PCC Hamilton
701 Main St. West - Unit 100
Hamilton, Ont, L8S 1A2
Tel: (289) 768 - PAIN (7246)
Fax: (289) 779 - CARE (2273)

Please Fax this form to (289) 779-CARE (2273)

If you have any questions about this form, please call our offices listed above

If you belong to a family health team (FHO, FHT) you will not be negated. Other CCFP physicians are in the process of obtaining their practice exemption and will be available to you soon.

Service * ☐ General Referral ☐ Wellness Program ☐ Rehabilitation

Referring MD / Allied Health Proffesional

Please fill out all that applies

Reffering MD / Allied Health Proffesional Name

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

MD Billing Number

Possess valid opiate prescribing license? ☐ Yes ☐ No

Office Billing Address

Office Phone Number

Office Fax Number

Office E-Mail

If different from above

Family MD

Office Billing Address

Office Phone Number

Office Fax Number

Office E-Mail

Individual Information

Name

Birthday mm / dd / yyy

Gender ☐ Male ☐ Female

Phone Number

Alternate Phone Number

Claim Number (if applicable)

Does the patient have 3rd party coverage? If yes, please provide insurance provider.

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Pain Diagnosis, if available

Current Medication List

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

Current/Previous specialists seen

Investigations

Medical History

Previous Pain Related Procedures

Are you the patients family physician or Most Responsible Physician (MRP)? ☐ Yes ☐ No

Physician Signature

Date