



# Mississauga Referral Application

PCC Mississauga  
6981 Millcreek Dr. - Unit 2  
Mississauga, Ont, L5N 6B8  
Tel: (289) 724 - PAIN (7246)  
Fax: (289) 914 - CARE (2273)

Please Fax this form to (289) 914 - 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 Professional

Please fill out all that applies

Referring MD / Allied Health Professional 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

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