



Orangeville Referral Application

PCC Orangeville
33A Broadway Avenue, Unit 1
Orangeville, Ont, L9W 1J7
Tel: (226) 780 - PAIN (7246)
Fax: (226) 790 - 2576

Please Fax this form to (226) 790-2576

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. As we are a teaching centre, if your patient is to be seen by one of our new physicians, we will contact you and ask that you temporarily de roster your patient.

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

Address City Postal Code

Phone Number Alternate Number Claim Number (if applicable)

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

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



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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 patient's family physician or Most Responsible Physician (MRP)? Yes No

As the most responsible physician, by signing the below, I agree to take over the patient's prescriptions and pain care once the patient is stable and ready to be discharged from PCC.

Physician Signature

Date

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