# St. Catharines Referral Application

**PCC St Catharines**
300 Fourth Avenue, Unit D
St Catharines, Ont, L2S 0E6
Tel: (365) 653 - PAIN (7246)
Fax: (365) 653 - 7247

Please Fax this form to (365) 653-7247

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 *****