Kitchener Referral Application

PCC Kitchener
800 King Street West, Second Floor Unit B
Kitchener, Ontario, N2G 1E8
Tel: 1 226 895 PAIN (7246)
Fax: 1 226 895 CARE (2273)

Please Fax this form to 226-895-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. 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 mm / dd / yyy

Gender ☐ Male ☐ Female

Address

City

Postal

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

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