



Niagara Referral Application

PCC Niagara
6360 Lundy's Lane
Niagara Falls, Ontario, L2G 1T6
Tel: 1 289 302 PAIN (7246)
Fax: 1 289 302 CARE (2273)

Please Fax this form to (289) 302-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

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.



Niagara Referral Application

PCC Niagara
6360 Lundy's Lane
Niagara Falls, Ontario, L2G 1T6
Tel: 1 289 302 PAIN (7246)
Fax: 1 289 302 CARE (2273)

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