PAIN CARE CLINICS

Referral Form

All Location Information:
www.paincareclinics.com

Please Fax this form to 1 (437) 703-5128

(Study participants must have been experiencing headache pain, neck pain or low back pain for more than 6 months)

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.

PCC Location Referral is being sent to:

☐ Niagara Falls ☐ St. Catharines ☐ Hamilton ☐ Oakville ☐ Mississauga
☐ Kitchener ☐ Orangeville ☐ Windsor ☐ Halifax

Service * ☐ Study (*not offered in Halifax) ☐ General Referral

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 Code

Phone Number | Alternate Phone Number | OHIP Number

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

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Pain Diagnosis (Neck Pain, Headache, or Low Back Pain)

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