SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Chronic Pain Clinic

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Chronic Pain Clinic Referral

Please fax to 905-830-5965

Patient Name: *(print first, last)*

Patient Address:

Patient Preferred Phone Number: | **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

Primary Care Physician Contact Number: | **WSIB Claim:** ❑ Yes ❑ No

Patient has consented to have the Pain Clinic leave a message on their answering machine at the number provided or speak with a member of their household regarding their appointment. ❑ Yes ❑ No

DESCRIPTION OF PAIN: _____

Allergies: _____ ❑ **No Known Allergies**

Pain Medications: _____

Past Medical History: ❑ CV _____ ❑ HTN _____ ❑ Diabetes _____ ❑ GI _____
❑ Kidney _____ ❑ Respiratory _____ ❑ Neuro _____ ❑ MSK _____ ❑ Blood Disorder _____
❑ Cancer _____ ❑ Previous Injury _____ ❑ Mental Health _____ ❑ Other _____

Social History: ❑ Tobacco/cigarettes: *(pack/day)* _____ ❑ Alcohol: *(drinks/day)* _____
❑ History of substance use/abuse: *(when? what?)* _____

Current/Past Treatment(s):
❑ Physiotherapy ❑ TENS ❑ Surgery: _____
❑ Nerve Block _____ ❑ Other: _____

Treatment results: _____

Investigations: ❑ X-ray _____ ❑ CT _____ ❑ MRI _____ ❑ Other _____

Please fax results of investigations.

❑ As Primary Care Physician, I agree to be responsible for any further prescriptions and required associated follow-up and clinical care following the Chronic Pain Clinic consultation and assessment.

❑ I am not the Primary Care Physician, but have contacted the Primary Care Physician Dr._____ and have confirmed his or her willingness to be responsible for any further prescriptions and required associated follow-up and clinical care following the Chronic Pain Clinic consultation and assessment.

❑ I have spoken with Pain Clinic Physician Dr. _____ and further prescriptions and required associated follow-up will be arranged by the Pain Clinic Physician once consultation and assessment has been completed.

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

I understand and agree that my patient will be seen in the Chronic Pain Clinic primarily for consultation and assessment.

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

Date referral received: dd / mm / yy | **APPOINTMENT – Date:** dd / mm / yy **Time:** _____