118-5045 Mainway, Burlington, Ontario, L7L 5Z1
Phone: (905)-315-7007, Fax: (289)-714-2516

REFERRAL FORM

PATIENT INFORMATION			
Surname:	First Name:		HC #:
DOB:	Sex:	Address:	
Home Phone #:			
Cell Phone #:		E-mail Address:	
Preferred Method of Contact: Phone Text E-mail			Consent Provided:
Interpreter Required? Yes No		On Disability? Yes No	
MVA Claim? Yes No		WSIB Claim? Yes No	
Extended Health Insurance? Private DND VAC NIHB			

PHYSICIAN INFORMATION		
Referring Physician:		Billing #:
Telephone #:	Fax #:	
Do you Belong to an FHT? Yes No		
Family Physician (if Different from Above):		
Billing #:	Telephone #:	Fax #:

MEDICAL HISTORY	
Surgical:	
Non-Surgical:	Diabetes Thyroid Disease Hypogonadism Headaches Seizures Stroke Sleep Apnea CAD Arrhythmia CHF PVD HTN Asthma COPD Liver Disease Kidney Disease GERD Gastritis PUD Arthritides Neuropathy Osteopenia Osteoporosis Fibromyalgia Rheumatic Autoimmune Disease Depression Anxiety PTSD Psychosis Cancer Hepatitis B/C HIV AIDS Substance Use Disorder Other:

CURRENT TREATMENTS
Is the Patient Using Opioids? Yes, Daily MED = _____ mg No
Suboxone? Yes, for Pain OUD, Daily Dose = ____ mg No
Methadone? Yes, for Pain OUD, Daily Dose = ____ mg No
Is the Patient Using Cannabinoids? Yes No
Is the Patient Using Benzodiazepines? Yes No
Other Sedatives? Yes No
Is the Patient Receiving Treatment at Other Pain Clinics? Yes No
Is the Patient Awaiting Surgery? Yes No

REASON FOR REFERRAL (We do not Address Cancer-Related Pain)	
Duration of Pain: < 3 Months 3 - 6 Months > 6 Months	
Migraine Headaches	Piriformis Syndrome
Post-Traumatic Headaches	Radiculopathy
Trigeminal Neuralgia	Peripheral Neuropathy
Tension-Type Headaches	Facet Joint Arthritis
Cervicogenic Headaches	Spinal Stenosis/ Neurogenic Claudication
Whiplash Injury	Post-Surgical Pain Syndrome
Mechanical/Myofascial Neck Pain	Complex Regional Pain Syndrome
Thoracic Myofascial Pain	Osteoarthritis
Mechanical/Myofascial Low Back Pain	Bursitis
SI Joint Dysfunction	Sprain/Strain
Degenerative Disc Disease	Plantar Fasciitis
Herniated Discs	Fibromyalgia
Other:	Rotator Cuff Sprain/strain/tears

SERVICES REQUESTED	
Is Patient on Antiplatelet or Anticoagulation Therapy? Yes No	
Procedural Referrals	**Non-Procedural Referrals**
Trigger Point Injections	Pharmacological Treatments
Bursa or Tendon Sheath Injections	Cannabinoid Treatment
Nerve Blocks Injections	<u>Physiotherapy</u>
Caudal Epidurals	Physical Rehabilitation
Botulinum Toxin Injections	TENS
<u>Ultrasound Guided Injections</u>	Shockwave Therapy
Peripheral Joint Injections	Laser Therapy
SI Joint Injections	Acupuncture
Facet Joint Injections	<u>Psychological Pain Management</u>
Viscosupplementation	Supportive counselling
PRP Injections	Psychotherapy
Barbotage Procedure	Cognitive Behavioural Therapy
	Mindfulness Based Techniques

I have attached all relevant investigations and specialist reports

I have asked the patient to take all their medications (not just a list) to their consultation

_____ _____

Referring Physician Signature **Date**