Avella Injury and Pain Management Center
5045 Mainway, Unit 118 Burlington, ON L7L 5Z1
Telephone #: 905-315-7007
Fax #: 289-714-2516

Website: www.avellapainclinic.com

Please complete and fax in this form

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 #:	
Does your patient belong to: ☐FHN ☐FHO ☐FHG ☐CCM ☐None ☐Other:________		
Family Physician (if Different from Above):		
Billing #:	Telephone #:	Fax #:

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

CURRENT MEDICATIONS

REASON FOR REFERRAL (We do not Address Cancer-Related Pain)

Duration of Pain: ☐ < 3 Months ☐ 3 - 6 Months ☐ > 6 Months

- ☐ Migraine Headaches
- ☐ Post-Traumatic Headaches
- ☐ Trigeminal Neuralgia
- ☐ Tension-Type Headaches
- ☐ Cervicogenic Headaches
- ☐ Whiplash Injury
- ☐ Mechanical/Myofascial Neck Pain
- ☐ Thoracic Myofascial Pain
- ☐ Mechanical/Myofascial Low Back Pain
- ☐ SI Joint Dysfunction
- ☐ Degenerative Disc Disease
- ☐ Herniated Discs
- ☐ Piriformis Syndrome
- ☐ Radiculopathy
- ☐ Peripheral Neuropathy
- ☐ Facet Joint Arthritis
- ☐ Spinal Stenosis/ Neurogenic Claudication
- ☐ Post-Surgical Pain Syndrome
- ☐ Complex Regional Pain Syndrome
- ☐ Osteoarthritis
- ☐ Bursitis
- ☐ Sprain/Strain
- ☐ Plantar Fasciitis
- ☐ Fibromyalgia
- ☐ Rotator Cuff Sprain/strain/tears

Other Reasons for Referral

PAIN SERVICES REQUESTED

Is the Patient on Antiplatelet or Anticoagulation Therapy? ☐Yes ☐No

	<u>Ultrasound Guided Injections</u>
☐ Trigger Point Injections	
☐ Bursa or Tendon Sheath Injections	☐ Peripheral Joint Injections
☐ Nerve Blocks Injections	☐ SI Joint Injections
☐ Caudal Epidurals	☐ Facet Joint Injections
☐ Botulinum Toxin Injections	☐ Viscosupplementation
	☐ PRP Injections
☐ Pharmacological Treatments	☐ Barbotage Procedure
☐ Cannabinoid Treatment	☐ Nerve Blocks

ADDICTION SERVICES REQUESTED

☐ Patients who are diagnosed with Opiate Use Disorder. This includes patients who are diagnosed with Opiate Use Disorder according to DSM 5 criteria. This includes both prescription opiates as well as non prescription opiates.

☐ Patients who have had a trial of other opiates for chronic pain and have developed unwanted side effects including Tolerance and/or Opiate Induced Hyperalgesia.

☐ Patients who have Contraindications for high dose opiates due to comorbid medical conditions and Suboxone could be a harm reduction strategy.

☐ Chronic Pain Patients Diagnosed with Alcohol Use Disorder.

☐ Patients who have been found to have other substances in their urine (i.e Cocaine or Methamphetamine) And cannot be continued on Opioid prescriptions due to contract violation.

<u>Note:</u>
*** Please submit the Cumulative Patient Profile (CPP) along with the <u>Diagnostic Reports/Results</u> ****
*** Please asked the patient to bring all their medications (not just a list) to their initial consultation ****

______________________________ **Referring Physician Signature**

______________________________ **Date**