

REFERRAL FORM

CAN YOU TRAVEL TO OUR LOCATION?

118 - 5045 Mainway, Burlington, ON L7L 5Z1

Yes No

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/FHO? 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

PAIN SERVICES REQUESTED

Is Patient on Antiplatelet or Anticoagulation Therapy? Yes No

Procedural Referrals

Non-Procedural Referrals

Trigger Point Injections Bursa or Tendon Sheath Injections Nerve Blocks Injections Caudal Epidurals Botulinum Toxin Injections <u>Ultrasound Guided Injections</u> Peripheral Joint Injections SI Joint Injections Facet Joint Injections Viscosupplementation PRP Injections Barbotage Procedure	Pharmacological Treatments Cannabinoid Treatment <u>Physiotherapy</u> Physical Rehabilitation TENS Shockwave Therapy Laser Therapy Acupuncture <u>Psychological Pain Management</u> Supportive counselling Psychotherapy Cognitive Behavioural Therapy Mindfulness Based Techniques
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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 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.

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