Avella Injury and Pain Management Centre

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5045 Mainway, Unit 118
Burlington, ON L7L 5Z1

338 Kerr Street
Oakville, ON L6K 3B5

387 Main Street East
Milton, ON L9T 1P7

Please complete and fax in this form

REFERRAL FORM

CLINIC LOCATION		
☐ **Burlington (Main Branch)** 5045 Mainway, Unit 118 Burlington, ON L7L 5Z1	☐ **Oakville** 338 Kerr Street Oakville, ON L6K 3B5	☐ **Milton** 387 Main St E Milton, ON L9T 1P7

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

Other Reasons for Referral

PAIN SERVICES REQUESTED	
Is the Patient on Antiplatelet or Anticoagulation Therapy? ☐ Yes ☐ No	
☐ Trigger Point Injections	Ultrasound Guided 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 Management	☐ Barbotage Procedure
☐ Medical Cannabinoid Management	☐ Nerve Blocks
☐ Ketamine Infusions	

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.

Note:

*** Please submit the Cumulative Patient Profile (CPP) along with the Diagnostic Reports/Results ****

*** Please asked the patient to bring all their medications (not just a list) to their initial consultation ****

Referring Physician Signature **Date**