



Avella Injury and Pain Management Centre

Phone #: 905-315-7007
Fax #: 289-714-2516
Website: avellapainclinic.com

Burlington (Main Branch)

5045 Mainway, Unit 118
Burlington, ON L7L 5Z1

Milton

395 Main Street East
Milton, ON L9T 1P7

Oakville

338 Kerr Street
Oakville, ON L6K 3B5

****Check services requested, then complete patient and physician details. Attach CPP and recent imaging/lab reports and fax the form.**

REFERRAL FORM

Referral Type

A: Specialty clinics

- The Migraine Clinic The Addictions Clinic The Rheumatology Clinic
 The Infusion Clinic The Rapid Knee OA Clinic

B: Pain/Interventional Services Requested

Is the patient on antiplatelet or anticoagulant therapy? Yes No

Ultrasound Guided Injections:

- | | |
|---|--|
| <input type="checkbox"/> Trigger Point Injections | <input type="checkbox"/> Peripheral Joint Injections |
| <input type="checkbox"/> Bursa or tendon sheath injections | <input type="checkbox"/> Sacroiliac (SI) Joint Injections |
| <input type="checkbox"/> Nerve Block injections | <input type="checkbox"/> Facet Joint Injections |
| <input type="checkbox"/> Caudal Epidural Injections | <input type="checkbox"/> Viscosupplementation |
| <input type="checkbox"/> Botulinum toxin Injections | <input type="checkbox"/> Platelet-rich plasma (PRP) Injections |
| <input type="checkbox"/> Pharmacologic pain management | <input type="checkbox"/> Peripheral Joint Injections |
| <input type="checkbox"/> Medical cannabinoid management | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rheumatology assessment/management | |
| <input type="checkbox"/> Ketamine infusions | |
| <input type="checkbox"/> Iron infusions – <i>please fill our Iron Infusions referral form</i> | |
| <input type="checkbox"/> Vyepiti Infusions | |

C: Addiction-Focused Referral (if applicable) (Check all that apply)

- Diagnosed Opioid Use Disorder (DSM-5)
 Use of non-prescription opioids (e.g., fentanyl, heroin)
 Chronic opioid therapy with:
- Tolerance
 - Suspected opioid-induced hyperalgesia
 - Contraindications to high-dose opioids due to comorbidities – considering Suboxone as harm reduction
 - Chronic pain patient with Alcohol Use Disorder
 - Other substances detected in urine (e.g., cocaine, methamphetamine) requiring change in opioid prescribing

D: Rheumatology-Focused Referral (if applicable)

- | | |
|--|--|
| <input type="checkbox"/> Inflammatory Arthritis / Polyarthritis | <input type="checkbox"/> Connective Tissue Disease |
| <input type="checkbox"/> Spondyloarthropathy | <input type="checkbox"/> Myositis |
| <input type="checkbox"/> Polymyalgia Rheumatica Giant Cell Arteritis | <input type="checkbox"/> Vasculitis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other : _____ | |

PATIENT INFORMATION

Last Name:		First Name:		Health Card #:	
DOB:		Sex:	Address:		
Home Phone #:			E-mail Address:		
Cell Phone #:					
Preferred Method of Contact: <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail				Consent Provided:	
Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No				On Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MVA Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				WSIB Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Extended Health Insurance? <input type="checkbox"/> Private <input type="checkbox"/> DND <input type="checkbox"/> VAC <input type="checkbox"/> NIHB					

PHYSICIAN INFORMATION

Referring Physician:		Billing #:			
Telephone #:		Fax #:			
Does your patient belong to: <input type="checkbox"/> FHN <input type="checkbox"/> FHO <input type="checkbox"/> FHG <input type="checkbox"/> CCM <input type="checkbox"/> None <input type="checkbox"/> Other: _____					
Family Physician (if Different from Above):					
Billing #:		Telephone #:		Fax #:	

CURRENT TREATMENTS

Is the Patient Using Opioids? Yes, Daily MED = _____mg <input type="checkbox"/> No
Suboxone? Yes, for <input type="checkbox"/> Pain <input type="checkbox"/> OUD, Daily Dose = _____mg <input type="checkbox"/> No
Methadone? Yes, for <input type="checkbox"/> Pain <input type="checkbox"/> OUD, Daily Dose = _____mg <input type="checkbox"/> No
Is the Patient Using Cannabinoids? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Patient Using Benzodiazepines? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Sedatives? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Patient Receiving Treatment at Other Pain Clinics? <input type="checkbox"/> Yes <input type="checkbox"/> 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

- | | |
|--|---|
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Radiculopathy |
| <input type="checkbox"/> Post-Traumatic Headaches | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Trigeminal Neuralgia | <input type="checkbox"/> Facet Joint Arthritis |
| <input type="checkbox"/> Tension-Type Headaches | <input type="checkbox"/> Spinal Stenosis/ Neurogenic Claudication |
| <input type="checkbox"/> Cervicogenic Headaches | <input type="checkbox"/> Post-Surgical Pain Syndrome |
| <input type="checkbox"/> Whiplash Injury | <input type="checkbox"/> Complex Regional Pain Syndrome (CRPS) |
| <input type="checkbox"/> Mechanical/Myofascial Neck Pain | <input type="checkbox"/> Osteoarthritis (site: _____) |
| <input type="checkbox"/> Thoracic Myofascial Pain | <input type="checkbox"/> Bursitis (site: _____) |
| <input type="checkbox"/> Mechanical/Myofascial Low Back Pain | <input type="checkbox"/> Sprain/Strain (site: _____) |
| <input type="checkbox"/> SI Joint Dysfunction | <input type="checkbox"/> Plantar Fasciitis |
| <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Herniated Discs | <input type="checkbox"/> Rotator Cuff Sprain/strain/tears |
| <input type="checkbox"/> Piriformis Syndrome | |

Other reason for referral:

Referring Physician Signature

Date