**Chronic Pain Clinic Referral**

**Patient Name:** (print first, last)

**Patient Address:**

**Patient Preferred Phone Number:**

**Patient Alternate Phone Number:**

**Primary Care Physician Name:** (if different from referring Physician) (print first, last)

**Primary Care Physician Contact Number:**

**WSIB Claim:**  
- [ ] Yes  
- [ ] No

Patient has consented to have the Pain Clinic leave a message on their answering machine at the number provided or speak with a member of their household regarding their appointment.  
- [ ] Yes  
- [ ] No

**DESCRIPTION OF PAIN:**

______________________________________________________________________________

**Allergies:**

[ ] No Known Allergies

**Pain Medications:**

__________________________________________________________________________________

**Past Medical History:**  
- [ ] CV  
- [ ] HTN  
- [ ] Diabetes  
- [ ] GI  
- [ ] MSK  
- [ ] Blood Disorder  
- [ ] Other

- [ ] Kidney  
- [ ] Respiratory  
- [ ] Neuro  
- [ ] Mental Health  
- [ ] Other

**Social History:**  
- [ ] Tobacco/cigarettes: (pack/day)  
- [ ] Alcohol: (drinks/day)  
- [ ] History of substance use/abuse: (when? what?)

**Current/Past Treatment(s):**  
- [ ] Physiotherapy  
- [ ] TENS  
- [ ] Surgery:  
- [ ] Other:

**Treatment results:**

______________________________________________________________________________

**Investigations:**  
- [ ] X-ray  
- [ ] CT  
- [ ] MRI  
- [ ] Other

Please fax results of investigations.

- [ ] As Primary Care Physician, I agree to be responsible for any further prescriptions and required associated follow-up and clinical care following the Chronic Pain Clinic consultation and assessment.

- [ ] I am not the Primary Care Physician, but have contacted the Primary Care Physician Dr. and have confirmed his or her willingness to be responsible for any further prescriptions and required associated follow-up and clinical care following the Chronic Pain Clinic consultation and assessment.

- [ ] I have spoken with Pain Clinic Physician Dr. and further prescriptions and required associated follow-up will be arranged by the Pain Clinic Physician once consultation and assessment has been completed.

**BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL**

I understand and agree that my patient will be seen in the Chronic Pain Clinic primarily for consultation and assessment.

**Referring Physician Name:** (print first, last)  
**Billing #:**

**Referring Physician Signature:**  
**Date:  dd / mm / yy**

**Phone Number:**  
**Fax Number:**

**CLINIC USE ONLY**

**Date referral received:**  dd / mm / yy

**APPOINTMENT – Date:**  dd / mm / yy  
**Time:**

*SL1279_06 (12/14) "Chronic Pain Clinic" Review (12/17)*