

## CHRONIC PAIN REFERRAL FORM

**We have Special Practice Exemptions. FHO physicians will not be negated in the RA**

Referring MD Name: \_\_\_\_\_ FHO Practice:  Yes  No

OHIP Billing Number: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Family Physician (if different from above): \_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Health Card Number & Version Code: \_\_\_\_\_

Health Card Expiry: \_\_\_\_\_ WSIB Claim Number(if WSIB): \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Alternate/Emergency Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Chief Complaint: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach copies of imaging reports as well as relevant consultations, treatments and surgical notes.

In referring my patient, I acknowledge that I will resume care of my patient after discharge from the Kitchener Pain Clinic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_