Ontario Pain Clinics

fax referrals to **(833) 610-PAIN (7246)**

CHRONIC PAIN REFERRAL FORM

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

Please check desired location (for details refer to the back of the form)

☐ Burlington	☐ Vaughan	☐ Hamilton	☐ Orangeville	☐ Kingston
☐ Guelph	☐ Newmarket	☐ St. Catharines	☐ Kitchener	☐ Tillsonburg
☐ North York	☐ Scarborough	☐ Tillsonburg	☐ Windsor	☐ Welland

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 **Ontario Pain Clinics**.

Signature: _____ **Date:** _____

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