Pain Management Clinic
Consultation Request
Phone: 705-474-8600 (3850) Fax: 705-495-7983

Referring Physician Information: Billing #: ______________________

Name: ______________________ Specialty: ______________________

Address: ______________________

Phone: ______________________ Fax: ______________________

Family Physician/Primary Care Provider (if different than above): ______________________

Patient Information: HCN: ______________________

Name: ______________________ Date of Birth (*dd/mm/yr*): ______________________

Address: ______________________

Phone: ______________________ Alternate Phone: ______________________

Reason for Referral:
☐ Consultation/Advice (Explain): ______________________
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☐ Treatment or Other (Specify): ______________________
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☐ Neuropathic Pain ☐ Back Pain ☐ Headache ☐ Pain and Chemical Dependency
☐ Craniofacial Pain ☐ Fibromyalgia ☐ Chronic Pain Management

When did the pain begin (specify as accurately as possible): ______________________
The pain is: ☐ getting worse ☐ improving ☐ unchanged/stable
Has the patient visited an EMERGENCY department as a result of this pain in the last 6 months? ☐ yes ☐ no
Is a return to work realistic with better pain control? ☐ yes ☐ no

Allied Services Utilized to Date:
☐ Acupuncture ☐ Osteopathy
☐ Bracing/Orthotics ☐ Psychotherapy
☐ Chiropractic

Date: ______________ Referring Physician Signature: ______________________

Print Name: ______________________

**** A primary care provider who is willing to participate in ongoing pain management is required****