Hamilton Pain Clinic

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Hamilton, ON L8L 3B4
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CHRONIC PAIN REFERRAL FORM

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

Referring MD Name: _____ FHO/FHT/FHN 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 Hamilton Pain Clinic.

Signature: _____ Date: _____