St.Catharines
PAIN CENTRE

464 Welland Ave
St. Catharines, ON L2M 5V4
Tel: (289) 606-0200
Fax: (289) 606-0222
www.stcatharinespaincentre.ca

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 St.Catharines Pain Centre.

Signature: _____ **Date:** _____