Centenary Pain Clinic
Patient Referral Form

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patient referral form

Patient Information

Name _____ DOB _____
first middle last dd/mm/yyyy

Phone Numbers _____ _____ _____
home cell work

OHIP _____ WSIB _____

Reason for Referral

☐ Transitional Pain Service

☐ Surgery _____ Date _____

The Transitional Pain Service provides consultation and management in the 3-6 month postoperative period for patients with a complex chronic pain history or for those at risk of developing chronic pain postoperatively.

☐ Chronic Neuropathic Pain

☐ Sciatica / Lumbar Radiculopathy ☐ Diabetic Neuropathic Pain ☐ Fibromyalgia
☐ Headaches ☐ Peripheral Nerve Pain ☐ CRPS
☐ Occipital Neuralgia ☐ Post-Surgical Neuropathic Pain
☐ Other _____

Additional Information

Prescribing Agreement: *(initial below)*
The patient must have a family physician prepared to be an active participant in his/her care. By signing below, I undertake to continue prescribing pain medications, including opioids, initiated by the Centenary Pain Clinic and will continue to provide ongoing care and follow up. **Initials:**_____

To avoid delays, please ensure the following is attached to the referral:
Diagnostic Imaging Reports (particularly MRI/CT), History of Presenting Complaint, Past Medical History, Complete List of Medications, Past Treatments

Referring Physician

Name _____ OHIP Provider _____

Signature _____ Date _____

FAX 416.287.0992 Centenary Pain Clinic