Chronic Pain Management Referral Form

800 John Marks Ave
Kingston, ON K7K 0J7
Phone: (613) 507-7246
Fax: (613) 344-1203

PATIENT INFORMATION

Name

Health Card No.

Address

DOB

Home Phone

Cell Phone

Email

REFERRING HEALTH CARE PROVIDER

Name

Signature

Billing No.

Phone

Fax

Address

PRIMARY HEALTH CARE PROVIDER (IF DIFFERENT FROM ABOVE)

Name

Billing No.

Phone

Fax

Address

Please briefly describe the reason(s) for the referral, including any clinical questions, diagnoses, description of symptoms, requested services, support needs, etc.

PAIN SITE (PLEASE CHECK ALL THAT APPLY)

- ☐ Complex Regional Pain Syndrome
- ☐ Acute Radiculopathy
- ☐ Facial, Headaches
- ☐ Neck, Back, Spine
- ☐ Joint Pain (hip, knee, shoulder etc)
- ☐ Widespread Pain/Fibromyalgia
- ☐ Gynecological Abdominal/Pelvic
- ☐ Non-Gynecological Abdominal/Pelvic
- ☐ Post Inguinal Hernia Surgery Pain
- ☐ Peripheral Nerve Injury
- ☐ Central Nerve Injury
- ☐ Other:

THE FOLLOWING DOCUMENTATION MUST BE ATTACHED. THIS REFERRAL WILL NOT BE COMPLETE UNLESS ALL RELEVANT INFORMATION IS RECEIVED.

- ☐ Relevant Diagnostic Imaging Reports
- ☐ Relevant medical history (attach Cumulative Patient Profile
- ☐ Specialist consultation notes relevant to pain management if available (Surgical consultations, GI, Gyne, Psychiatry etc)