Scarborough
CHRONIC PAIN CLINIC

4218 Lawrence Ave E, Unit 4
Scarborough ON M1E 4X9
Tel: (437) 826-2000
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www.scarboroughchronicpainclinic.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 Scarborough Chronic Pain Clinic.

Signature: _____ **Date:** _____