DUNDAS
PAIN CLINIC

Physician Referral

Fax completed form with supporting notes

FAX: (905) 291-3840 | PHONE: (289) 452-1160

1. Patient Details

OHIP # _____ Version _____ Date of Birth _____

Full Name _____ Cell _____ Other Phone _____

Address _____ City _____ Postal Code _____

Province _____ Extended health / auto / WSIB insurer (if any): _____

Referral type: ☐ First referral ☐ Returning patient ☐ Work / auto injury Substance use history? ☐ Yes ☐ No

2. Referring Provider

Name _____ CPSO / CNO # _____ OHIP Billing # _____

Clinic Address _____ Tel _____ Fax _____

Is this patient rostered to you? ☐ Yes ☐ No

Practice model: ☐ FHO ☐ FHT ☐ FHG ☐ CCM ☐ Other _____

3. Clinical Details

Pain location: ☐ Head / Migraine ☐ Neck ☐ Shoulder ☐ Back ☐ Hip ☐ Knee ☐ Other _____

Service: ☐ Consult & Meds ☐ Joint/Bursa Injection ☐ Trigger Point ☐ Botox for Migraine ☐ Assess & Treat

Pain for: ☐ < 3 months ☐ 3–12 months ☐ > 1 year Urgency: ☐ Routine ☐ Urgent

Working diagnosis, history & treatments tried:

Please attach

- Cumulative patient profile
- Recent imaging and specialist notes
- Medication list (flag blood thinners)
- Allergies

Sign-off

Signature _____

Date _____

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