CHRONIC PAIN TREATMENT CENTRE

Referrals from the Emergency Department will be seen within 5 days of referral

Patient Information:

Name:	Date of Birth:	HCN#:
Address:	Telephone:	
Name of Family Doctor (if known):		

Indications for referral:

***chronic pain present for > 3 months**

☐ low back pain
☐ chronic headaches
☐ lumbar epidurals
☐ fibromyalgia
☐ MVA
☐ post operative pain
☐ pain related opioid management

Referring Physician

Name:
MOH Physician:

Area of Pain

☐ cervical spine
☐ lumbar spine
☐ thoracic spine
☐ shoulder pain
☐ leg pain
☐ headaches
☐ other: _____

Diagnoses and Syndromes

_____
_____
_____
_____

Any known history of substance abuse or dependence? ☐YES ☐NO

LOCATION

1017 Wilson Avenue
Suite 100B
Toronto, ON M3K 1Z1
T: (416) 613-8373

Please fax completed form to:

(416) 613-8374