

Signature:

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www.kingstonpainclinic.ca

CHRONIC PAIN REFERRAL FORM

We have Special Practice Exemptions. FHO physicians will not be negated in the RA

OHIP Billing Number: Telephone: Fax:	Referring MD Name:	FHO Practice: □ Yes □ No	
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			
Patient Health Card Number & Version Code: Health Card Expiry: WSIB Claim Number (if WSIB): Telephone Number: Alternate/Emergency Phone: 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	Family Physician (if different fr	om above):	
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	Patient Name:		Date of Birth:
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	Patient Health Card Number &	Version Code:	
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	Health Card Expiry:	WSIB Claim Number (if WSIB):	
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	Telephone Number:	Alternate/E	Emergency Phone:
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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	Chief Complaint:		
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the Kingston Pain Clinic.	In referring my patient, I acknowle the Kingston Pain Clinic.	edge that I will resume ca	re of my patient after discharge from

Date: