Centre for Pain Care
SILVER MEDICAL GROUP

4646 Dufferin Street, Unit 9 • Toronto, ON M3H 5S4
Tel: 416.512.6407• Fax: 416.512.6375
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Physician Referral Form

According to CPSO Policies the Consultation requests should include:● Reasons for referral ● Urgency ● Relevant medical history ● Current medications ● All relevant test and procedure results

Incomplete referrals will result in a delay in patient care

Referring MD:_____Billing#:_____
Address: _____ Phone:_____
Fax:_____Email:_____

Patient Name:_____
HCN:_____ D.O.B. _____
Address:_____ Home Phone:_____ Alternative Phone:_____

1. Service requested: Consultation ☐ Procedure ☐ Multidisciplinary Care ☐ Other:_____

2. Reason for Referral: _____

☐ Headache	☐ Pelvic/Abdominal Pain	☐ Neck Pain
☐ Back Pain	☐ Radiculopathy	☐ Arthritis/Musculoskeletal
☐ CRPS/RSD	☐ Neuropathy	☐ Fibromyalgia/Widespread Pain

3. Is your patient problem related to: MVA ☐ Disability Claim ☐ Work Injury ☐ Assault ☐

4. Medical/Psychiatric History: **ATTACHED** ☐ CV ☐ COPD ☐ Stroke/TIA ☐ OA/RA ☐ PVD ☐ Diabetes ☐ OSA ☐ Mental Disorder ☐ Substance Abuse ☐

5. Surgical/Trauma History: **ATTACHED** ☐ Was operated to treat pain ☐ Pain appeared after surgery/trauma ☐

6. Medications: **ATTACHED** ☐ Anticoagulant/Antiaggregant ☐ Opioids ☐ Benzodiazepines ☐ Medicinal Cannabis ☐ Anticonvulsant/Antidepressant ☐ OTC ☐

7. Previous Treatments: **ATTACHED** ☐ Medications ☐ Injections ☐ Multidisciplinary ☐ PT ☐ Complimentary Medicine ☐

8. Social History: Employed ☐ Unemployed ☐ ODSP ☐ Retired ☐ Other Source of Income ☐

Signature_____Date_____

Please complete the above information and fax along relevant reports to

Please explain to your patient:

1. The clinic coordinator will contact him/her by phone to arrange the appointment
2. Your patient may be asked to complete health assessment forms either online or pen-and-paper
3. On the appointment, day patient must have an updated medication and allergies list
4. We request reports of all relevant consultations and imaging to be sent before the scheduled visit
5. Patient may be asked to obtain CD of the imaging studies

[**for Family Physicians**] I will resume care of my patient after discharge from the Unika Medical Centre and/or will co-manage his/her chronic pain with accordance to the recommendations.

I acknowledge that I have relayed the reason and goals of this referral to my patient.

Signature_____

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