Centre for Pain Care
SILVER MEDICAL GROUP

9 – 4646 Dufferin Street, Toronto, ON M3H 5S4
Tel: 416.512.6407 • Fax: 416.512.6375
1.800.807.0078 • referral@silverpaincare.com

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#:__________ FHO/FHN: Yes ☐ No ☐ HELP Program: Yes ☐ No ☐

Address:____Phone:____________________________

Fax:____Email: ____________________________

Patient Name:______________________________________D.O.B.___________

HCN:____

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

Medications: ◻ **ATTACHED** ◻ Anticoagulant/Antiaggregant ◻ Opioids ◻ Benzodiazepines ◻ Medical 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 416-512-6375.

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 in person
3. On the appointment day, patient must have an updated medication and allergies list
4. We may 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 Silver Medical Group – Centre for Pain Care and/or will co- manage his/her chronic pain with accordance to the recommendations.

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

Signature____Date________________