

Non-Narcotic Medical Pain Management

Please complete and Fax this form to 1 (866) 380-2423

Patient Info

Health Card No _____ VC _____ Date of Birth _____

Full Name _____ Main Tel./Mobile _____ Alt.Tel. _____

Address _____ City _____ Postal Code _____

Province _____ Does this patient have 3rd party coverage? If yes, please provide insurance provider: _____

This patient is a: New Patient Re-referral History of drug/alcohol abuse or addiction? Yes No

Physician Info

CPSO # _____ Billing # _____

Dr./NP _____ Tel _____ Fax _____

Address _____ City _____ Postal Code _____

Province _____ Are you the patient's Family Physician or Most Responsible Physician (MRP)? Yes No

Do you belong to a: FHO FHT FHG CCM Other _____

Reasons for Referral

Medical Problem/Diagnosis: Headaches Migraines Neck Pain

Onset (since when): _____ Duration: _____

Location: _____ Imaging Results: _____

Medications Tried: _____

Previous Consults (Neurology, Pain Clinic): _____ Other: _____

Current Medication/Supplements: _____

To expedite the referral, please provide:

- Patient's Medical History
- Diagnostic and/or consultation reports
- Current Medications

As the most responsible physician, by signing below, I agree to continue the patient's prescription and primary care once the patient is stable and under the care of HMCC.

Physician Signature

Date