niagarahealth

Extraordinary Caring. Every Person. Every Time.

Pain Clinic Referral

Patient Information:

Last Name:	First Name:	Health Card / Version Code:
Date of Birth: (dd/mm/yyyy)	Street:	City / Postal Code:
Contact Number(s):		

Referring Provider Information:

Referring Provider Name:		CPSO Number:
Phone:	Fax:	Date: (dd/mm/yyyy)
Referring Provider Signature:		

Reason for Referral ☐ **Active Insurance Claim** ☐ **Active WSIB Claim**

Location of Pain: _____

Referral Pattern: _____

Duration of Pain: _____

Clinical Summary: _____

_____

Type of Assessment

Urgent Assessment: ☐ Yes ☐ No Reason: _____

Specific Procedure: ☐ Yes ☐ No Reason: _____

Interventional Pain Referral: ☐ Yes ☐ No

All referrals must be accompanied by the specific imaging as outlined below:

Peripheral Joint Pain / Arthritis: X−ray, CT **or** MRI

Soft Tissue Pathology: Ultrasound **or** MRI

Radiculopathy: CT, MRI **and** EMG

Peripheral Mononeuropathy: EMG

Neuropathy: EMG

Cannabis for Pain: Relevant Imaging

Rev. 10/2022(v1)

Pain Clinic Contact Information:

Telephone: 905−378−4647 Ext. 44758 **Fax: 289−398−0195** **Hours: Thursday and Friday 0800 − 1600**

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