

# Brantford

## PAIN CLINIC

347 Colborne Street East  
Brantford, Ontario N3S 3N2  
Tel: (226) 493-1418  
Fax: (226) 493-1477  
brantfordpainclinic.ca

### CHRONIC PAIN REFERRAL FORM

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

Referring MD Name: \_\_\_\_\_ FHO Practice: ☐ Yes ☐ No

OHIP Billing Number: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Family Physician (if different from above): \_\_\_\_\_

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 the Brantford Pain Clinic.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_