

# Burlington Chronic Pain Clinic

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Burlingtonchronicpain.com

## Patient Information:

Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ (dd/mm/yy)

HCN#: \_\_\_\_\_

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

Contact Telephone: \_\_\_\_\_

*Affix Patient Label Here*

## Patient Referral Form: Chronic Pain Management

### Our Services:

- **Comprehensive Consultation** and multimodality plan for managing chronic pain
- **Mental Health** counselling
- **Rehabilitative/Exercise** counselling
- **Adjunct Pharmacotherapy** prescribing for chronic pain
- **Opioid Counselling** in strict keeping with 2017 Canadian Opioid Guidelines
- **Cannabinoid** prescribing for chronic pain
- **Interventional Treatments** for chronic pain
- **Epidural Corticosteroids** for chronic pain
- **Botox** for chronic migraines
- **We speak Polish**

### Reason for Referral:

- Low Back Pain**
- Neck Pain**
- Neuropathic Pain** including sciatica, post-herpetic neuralgia
- Headaches** including tension, migraine, cluster
- Joint Pain** including hip, knee, shoulder
- Fibromyalgia**
- Rheumatologic** conditions including rheumatoid arthritis, polymyalgia rheumatica
- Complex Regional Pain Syndrome**
- Chronic **Post-MVA** pain
- Other: \_\_\_\_\_

Pain Duration \_\_\_\_\_  weeks  months  years

History of Substance/Alcohol Abuse:  yes  no

**Current Medications:**

**Treatment/Responses to Date:**

**Additional Information:**

*Please include all applicable investigations including imaging, bloodwork and consultation reports with referral*

### **Referring Physician**

Name:

Address:

Phone/Fax:

MOH Billing Number:

FHO/FHN Practice:  yes  no

### **Family Physician (if different from referring physician)**

Name:

Address:

Phone/Fax:

MOH Billing Number:

FHO/FHN Practice:  yes  no