Health Sciences North/Horizon Santé Nord 865 Regent Street South
Integrated Chronic Pain Program Phone 705-523-7100 ext. 2755
REFERRAL FORM Fax 705-671-5678

Patients with current WSIB or MVA claims not eligible.

PATIENT INFORMATION	
Last Name:	**First Name:**
HCN:	**Date of Birth (YYYY/MM/DD)**
Address:	
Patient's Preferred Phone Number #:	
Patient's Email Address:	

REFERRING HEALTH CARE PROVIDER INFORMATION	
Referring Provider Name:	**Fax #**
Primary Care Provider (if different from above):	

CLINICAL INFORMATION

Duration of Pain: ☐ 3 -6 months ☐ More than 6 months

Primary Site of Pain:

☐ Head ☐ Neck ☐ Limb ☐ Upper / Mid Back
☐ Chest ☐ Abdomen ☐ Pelvis ☐ Low Back
☐ Cancer Pain ☐ Migraine/TMJ ☐ Other (specify): _____

Date of onset of pain (YYYY/MM):

Was there an inciting event?

Previous Treatment Strategies:

☐ Acetaminophen with Codeine ☐ Tricyclic Anti-Depressants ☐ Opioids ☐ NSAIDs
☐ Cannabinoid / Marijuana ☐ Gabapentin / Lyrica ☐ Massage ☐ Psychology
☐ Physiotherapy ☐ Surgery: _____
☐ Nerve Blocks / Infusion Therapy ☐ Other: _____

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ADDITIONAL INFORMATION REQUIRED (missing information may delay triage time)
☐ Relevant Medical History
☐ Current Medication List
☐ Relevant Imaging (within past 5 years)

REFERRING PROVIDER AGREEMENT	
• Primary Care Providers are expected to play an active role with their patients. • The Clinic will provide an assessment and recommended treatment plan. • The Clinic won't take over prescribing or primary care responsibilities. • Once patient goals are met, the patient will be returned to you for ongoing care. **If in agreement, please sign this form and return to us:**	
PRINTED NAME	
SIGNATURE	
DATE	

FAX COMPLETED REFERRAL
INCLUDING ADDITIONAL INFORMATION REQUIRED
TO: 705-671-5678

- You will receive a fax from the Clinic confirming receipt of this referral.
- Patients are only contacted when an intake appointment is available.
- There is a minimum 6 month wait for intake with the **multidisciplinary team**.