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Dr. Allison Blain, B. Sc, B Ed, MD, FRCPC – practicing in Pain Management and Opioid Addiction

Dr. Ann Griffin MD, MPH, FRCPC– practicing in Pain Management and Opioid Addiction

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☐ **Pain & Dependency Referral Request Form – Please Fax to 905.631.1400** ☐

Patient: _____ HCN: _____ VC _____

Address: _____ City _____

Postal Code _____ DOB: _____

Patient Home Phone #: _____ Cell # _____

Referring Physician: _____ CPSO # _____

Phone# _____ Back Line# _____

Fax # _____ Email: _____

Address: _____ City _____ PC _____

Current Pain Diagnosis: _____

Please note if there is a known history of alcohol or drug abuse/addiction: YES _____ NO _____ UNCERTAIN _____

Brief Description of any Dependency/Addiction Issues if applicable:

Please indicate all previous treatments (check all that apply): Acetaminophen _____ Acupuncture _____
Antidepressants _____ Cannabinoids _____ Counselling _____ Nerve Blocks _____
NSAIDs/COXIBs _____ Opioids _____ Methadone/Suboxone _____

Other (please specify)

Current Treatments and Medications: (please attach list if there is insufficient space): _____

Past Surgeries (please also include year): _____

Please note: Attach all Investigations to our referral form when submitting. The following reports are attached (please check):

Investigations: Imaging Reports _____ Relevant Lab Work _____ EMG/NCS _____ MRI _____

Consults: Neuro _____ Neurosurg _____ Ortho _____ Pain _____ Physiatry _____ Psych _____ Rheum _____

I acknowledge that I am the primary care physician and no opioids will be prescribed to my patient without my knowledge. I acknowledge and have read the conditions of the referral and will resume care of my patient after discharge from Wellbeings if treatments are .

Physician's Signature: _____

Date: _____

Total Number of pages in this Referral are: _____