wellbeings®
pain management & dependency clinic

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Dr. Allison Blain, B. Sc, B Ed, MD, FRCPC – practicing in Pain Management and Opioid Addiction
Dr. Angel Carol, MD, FRCPC – practicing in Pain Management
Dr. Darren Holub, MD, RCPSC – practicing in Opioid Addiction
Dr. Kumar Kelkar MD, FRCPC – practicing in Opioid Addiction
Dr. Sheema Sharieff, MD, FRCPC – practicing in Pain Management and Opioid Addiction
Dr. Suneel Upadhye MD, MSc, FRCPC – practicing in Pain Management

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: _____

Billing Referral #: _____ Phone#: _____

Back Line#: _____ Fax#: _____ Email: _____

Address: _____ City: _____ PC: _____

Current Pain Diagnosis: _____

Is there a known history of alcohol or drug abuse/addiction? Yes ___ No___
Uncertain____
Would you like to partner in medical management for opioid use? Yes ___ No ___
Is the patient currently using opioids? Yes ___ No ___
Is the patient taking >90mg ME/day? Yes ___ No ___ _____

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 a list if there is insufficient space):

_____

_____

_____

_____

_____

_____

_____

Please note: Attach all investigations to our (this) 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.

Physician's Signature: _____ Date: _____

Total number of pages in this referral are: _____