185 Plains Road East, Unit 1
Burlington, ON L7T 2C4
Tel: 905.631.9355 (WELL)
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Dr. Allison Blain, B. Sc, B Ed, MD, FRCPC – practicing in Pain Management & Opioid Use Disorder
Dr. Angel Carol, MD, FRCPC – practicing in Pain Management, Opioid Use Disorder & Alcohol Use Disorder
Dr. Darren Holub, MD, RCPSC – practicing in Opioid Use Disorder & Alcohol Use Disorder
Dr. Kumar Kelkar MD, FRCPC – practicing in Opioid Use Disorder & Alcohol Use Disorder
Dr. Sheema Sharieff, MD, FRCPC – practicing in Pain Management and Opioid Use Disorder
Dr. Suneel Upadhye MD, MSc, FRCPC – practicing in Pain Management

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Pain & Dependency Referral Request Form – Please Fax to 905.631.1400

Patient _____ HCN:_____ VC: _____

Address: _____ City: _____

Postal Code: _____ DOB: _____ Email: _____

Patient Home Phone #: _____ Cell #: _____

***Referring Physician:** _____ *CPSO #: _____

*Billing Referral #: _____ Office #: _____

*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 disorder? Yes ❑ No ❑
Is the patient currently using opioids? Yes ❑ No ❑
Is the patient taking >90mg ME/day? Yes ❑ No ❑
Would you like a second opinion only for your patient taking >90mg ME/day? Yes ❑ No ❑
Brief description of any Dependency/Addiction issues if applicable:

_____

Please fill in all fields indicated with *

wellbeings®
pain management & dependency clinic

Pain & Dependency Referral Request Form

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 ❑ Psychiatry ❑ 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: _____

Wellbeings® has 2 GP's with focused practices in pain management and addictions. If you require their specific services because of the OHIP model you work within please check this box so that your practice will not be affected: ❑ Your initials: _____

Total number of pages in this referral are: _____