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wellbeings®
pain management & dependency clinic

Dr. Michael Boucher, MD, DCAPM, CIME - Medical Director, Wellbeings®

Dr. Allison Blain, B.Sc, B.Ed, MD, FRCPC - practising in Pain Management and Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD)

Dr. Angela Carol, MD, CCFP, FCFP - practising in Pain Management and Addiction Medicine

Dr. Navot Kantor, MD, CCFP - practising in Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD)

Dr. Priyanka Kapil, MD, CCFC - practising in Opioid Use Disorder (OUD), Substance Use Disorder (SUD including AUD and cocaine)

Dr. Geoffrey Purdell-Lewis, B.Sc, MBBS, FRCPC - practising in Pain Management

Dr. Suneel Upadhye, MD, M.Sc, FRCPC - practising in Pain Management

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Referral Request Form - Please Fax to: 905.631.1400 Please print legibly.

Patient: _____ HCN: _____ VC: ____

Address: _____ City: _____

Postal Code: _____ DOB (dd/mm/yyyy): _____

Patient Home Phone: _____ Patient Cell Phone: _____

Referring Physician: _____ CPSO#: _____

Billing Referral #: _____ Phone #: _____

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

Address: _____ City: _____ Postal Code: _____

Current Diagnosis: _____

Is there a known history of alcohol and/or drug abuse/addiction? Yes ____ No ____ Unsure ____

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 an extra page if there is insufficient space):

_____

_____

_____

_____

_____

Please note: Attach all investigations to 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 this patient is currently under my care and I have the authority to make this referral. I acknowledge and have read the conditions of the referral and will resume care of my patient after discharge from Wellbeings, if I am part of a rostered practice.

Please know that if you are the primary care physician, no opioids will be prescribed to your patient without your knowledge unless the patient refuses to allow disclosure.

Physician's Signature: _____ Date: _____

The Physician is a member of a FHO? Yes _____ No _____
Total number of pages in this referral are: _____