MD/NP Referral Form
Chronic Pain Management Assessment & Referral Program

Tel: 1.855.419.5200 ext. 4
Fax #: 1-855-492-2963

Please fully complete the following information to ensure accurate processing

Referral Date (mm/dd/yy):	Health Card #:	VC:
Last Name:	First Name:	Middle Initial:
Gender: ☐Male ☐Female	Date of Birth (mm/dd/yy):	Age:
Address (Street, Province, PC):		
Home Phone #:	Mobile Phone #:	Work Phone #:

Referring Practitioner (Please Print Name):	
Address (Street, Province, PC):	
Business Phone #:	Fax #:
Signature:	
I understand that this is a collaborative consultative approach and that as the Primary Care Provider, I will continue to facilitate the overall management of the client's chronic pain matter.	

Clinical Information ***(Please include reason for referral, and pain details including length of time):***

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Current/Past Treatments/Tests *(Please attach results and provide copies of all relevant investigations/consultations):*

__ Physiotherapy __ TENS __ Injections __ Surgery Other: _____

__ CT Scan/MRI __ X-Rays **Please attach recent medication profile** *(Within 6 months)*

***Chronic Pain Management Assessment & Referral Program (CPMARP) Requirements for Client Eligibility**
Please note that the purpose of this program is to provide each referred client with comprehensive pain assessments, treatment options, and recommendations for ongoing pain management in order to help increase the quality of life for the clients. **The CPMARP Eligibility is:**

- Non cancer related chronic pain
- Not considered end of life (palliative comfort care)
- Chronic pain greater than 3 consecutive months