CHRONIC PAIN TREATMENT CENTRE

Patient Information:

Name:	Date of Birth:	HCN#:
Address:	Telephone:	

Referring Physician

Name:
MOH Physician #

Family Physician (*If different than referring source)*

Name :
Phone:
Fax:

Please check the applicable practice model:
☐ FHT ☐ FHG ☐ FHN ☐ FHO
Other:
_____

Area of Pain

□ cervical spine
□ lumbar spine
□ thoracic spine
□ shoulder pain
□ leg pain
□ headaches
□ other: _____

Diagnoses and Syndromes

_____
_____
_____
_____

We recognize that safely managing patients with opiates is challenging in a community office setting. We endeavor to make concise recommendations regarding use of opioids contracts, screening tools and pill counting. However, if you prefer that we defer or avoid the use of opioids, please check this box: ☐

Any known history of alcohol or drug abuse/addiction? □YES □NO

LOCATION

1017 Wilson Avenue
Suite 104
North York, ON M3K 1Z1
T: (416) 613-8373

Please fax completed form to:

(416) 613-8374