# Newmarket Pain Clinic

**16715 Yonge Street Unit 22B,**
Newmarket, ON L3X 1X4
Phone: (905) 898-4184
Fax: **(905) 898-5793**
**www.newmarketpainclinic.ca**

## CHRONIC PAIN REFERRAL FORM

**We have Special Practice Exemptions. FHO physicians will not be negated in the RA**

**Referring MD Name:** _____ **FHO Practice:** □ **Yes** □ **No**

**OHIP Billing Number:** _____ **Telephone:** _____ **Fax:** _____

**Address:** _____

**Family Physician (if different from above):** _____

**Patient Name:** _____ **Date of Birth:** _____

**Patient Health Card Number & Version Code:** _____

**Health Card Expiry:** _____ **WSIB Claim Number(if WSIB):** _____

**Telephone Number:** _____ **Alternate/Emergency Phone:** _____

**Address:** _____

**Chief Complaint:** _____

**Current Medications:** _____

Please attach copies of imaging reports as well as relevant consultations, treatments and surgical notes.

In referring my patient, I acknowledge that I will resume care of my patient after discharge from the Newmarket Pain Clinic.

**Signature:** _____ **Date:** _____