Silver Pain Centre
Partners in Pain Management

4646 Dufferin Street, Unit 9, Toronto, ON M3H 5S4
Tel: (416) 512-6407 | Fax: (416) 512-6375 | 1 (800) 807-0078
referral@silverpaincentre.ca

SilverPainCentre.ca

Patient Referral Form

Preferred Silver Physician:

FHO/FHN: Yes ☐ No ☐
HELP Program: Yes ☐ No ☐

Physician Information

Referring MD: _____ Billing #: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Patient Information

Patient HCN: _____ Version Code: _____ Expiry Date: _____

Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

1. Service requested: Consultation only ☐ Second Opinion ☐ Image-Guided Procedure ☐ IV Infusions ☐ Other: _____

2. Reason for Referral: _____

3. Is your patient's problem related to: ☐ MVA ☐ Disability Claim ☐ Work Injury ☐ Assault

4. Medical/Psychiatric History: ☐ **ATTACHED** ☐ CV ☐ COPD ☐ Stroke/TIA ☐ OA/RA ☐ PVD ☐ Diabetes ☐ OSA ☐ Mental Disorder ☐ Substance Abuse

5. Surgical/Trauma History: ☐ **ATTACHED** ☐ Was operated to treat pain ☐ Pain appeared after surgery/trauma

6. Medications: ☐ **ATTACHED** ☐ Anticoagulant/Antiaggregant ☐ Opioids ☐ Benzodiazepines ☐ Medical Cannabis ☐ Anticonvulsant/Antidepressant ☐ OTC

7. Previous Treatments: ☐ **ATTACHED** ☐ Medications ☐ Injections ☐ Multidisciplinary ☐ PT ☐ Complimentary Medicine

8. Social History: ☐ Employed ☐ Unemployed ☐ ODSP ☐ Retired ☐ Other Source of Income

Signature: _____ **Date:** _____

Please complete the above information and fax (or email to referral@silverpaincentre.ca) along with relevant reports to (416) 512-6375.

Please explain to your patient:

1. The clinic coordinator will contact your patient by phone to arrange the appointment.
2. Your patient may be asked to complete health assessment forms either online or in person.
3. On the appointment day, patient must have an updated medication and allergies list.
4. We may request reports of all relevant consultations and imaging to be sent before the scheduled visit.
5. Patient may be asked to obtain a CD of imaging studies or electronic access to review online.

For Family Physician

☐ Please review and acknowledge.

I will resume care of my patient after discharge from the Silver Pain Centre and/or will co-manage his/her chronic pain in accordance with the recommendations.

I acknowledge that I have explained the reason and goals of this referral to my patient.

Signature: _____

Date: _____

According to CPSO policies, the consultation request should include:

• Reason for referral • Urgency • Relevant medical history • Current medications • All relevant test and procedure results

Incomplete referrals will not be processed and will result in delay of patient care.