PAIN & WELLNESS CENTRE

2301 Major Mackenzie Drive West, Unit 101, Vaughan, ON L6A 3Z3
1-(800)-597-5733 (Main Office) 1-(844)-358-9308 (Toll Free Fax)
info@thepwc.ca
www.thepwc.ca

Chronic Pain Referral for Assessment

Patient Information:

Name of Patient: _____ Sex of Patient: _____

Full Mailing Address: _____

Patient Phone Number(s): _____

DOB: (DD/MM/YYYY): _____ HCN: _____

Does Patient Speak English?

☐ Minimal ☐ Fair ☐ Good/Fluent

Referring Provider Information:

Name of Referring Provider: _____

Mailing Address of Referring Provider: _____

Phone Number: _____ Fax Number: _____

Date: _____ Billing Number: _____

Family Physician: _____

Reason for Referral:

- ☐ Chronic Widespread Pain
- ☐ Low Back Pain
- ☐ Other (Specify in Comments)

Comments

Pain Result Of:

- ☐ Car Accident
- ☐ Work Injury
- ☐ Slip & Fall
- ☐ Other (Specify in Comments)

Comments

Please Note: **NO MORE** Than **20 Pages** of Relevant Files

Referral Will **NOT** Be Accepted Without:

- ☐ CPP or Brief Medical History (Including Psychiatric History)
- ☐ Relevant Imaging
- ☐ Relevant Consultations