CHRONIC PAIN MANAGMEENT REFERRAL FORM

Please complete and fax or email this form

EMAIL: info@releva.ca **PHONE:** 416.747.8008 **FAX:** 647.977.2757 **WWW:** www.releva.ca

Releva Chronic Pain Centre

PATIENT INFORMATION

Patient Name | Contact Phone | HCN#

Address

Date Of Birth | Day | Month | Year

PAIN CONDITION(S)

Please complete and fax or email this form

Low Back Pain ☐ Headaches/Migraines ☐ Neuropathic pain ☐ Neck Pain ☐

Shoulder Pain ☐ Complex Regional Pain Syndrome ☐ Fibromyalgia ☐

Other: | Pain Duration

Treatments and responses to date:

Additional information:

Referral Information

Referring Provider Name | Provider Type

Address

Phone | Fax

Family Physician Name

Address

Phone | Fax

Location

☐ **Etobicoke**, 1770 Albion Rd M9V ☐ **Mississauga**, 1224 Dundas St W, L5C 4G7

Consent

☐ Patient advised to make their Family Physician aware of referral to Releva Chronic Centre. Consultation reports will be sent to the Referring Provider and Family Physician.

☐ Patient advised that referral to Releva Chronic Pain Centre is only for interventional management of their pain. If assessment of any other pain is required, a referral from the Family Physician will be required.

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Print Form