Burlington Chronic Pain Clinic

Dr. Nadia Salvo

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Patient Information:

Name: _____

Date of Birth: ___/___/___(dd/mm/yy)

HCN#: _____

Address: _____
_____

Contact Telephone: _____

Affix Patient Label Here

Patient Referral Form: Chronic Pain Management

Our Services:

- **Comprehensive Consultation** and plan for managing chronic pain
- **Rehabilitative/Exercise** counselling
- **Adjunct Pharmacotherapy** prescribing for chronic pain
- **Opioid Counselling** in strict keeping with 2017 Canadian Opioid Guidelines
- **Interventional Treatments** for chronic pain
- **Botox** for chronic migraines

NB: We do not start interventional treatment trials without prior imaging

Reason for Referral:

□ **Low Back Pain**
□ **Neck Pain**
□ **Neuropathic Pain** including sciatica, post-herpetic neuralgia
□ **Headaches** including tension, migraine, cluster
□ **Joint Pain** including hip, knee, shoulder
□ **Fibromyalgia**
□ **Rheumatologic** conditions including rheumatoid arthritis, polymyalgia rheumatica
□ **Complex Regional Pain Syndrome**
□ Chronic **Post-MVA** pain
□ Other: _____
_____

Pain Duration _____ □ weeks □ months □ years

History of Substance/Alcohol Abuse: □ yes □ no

Current Medications:
Treatment/Responses to Date:
Additional Information:

Please include all applicable investigations including imaging, bloodwork and consultation reports with referral

Referring Physician	**Family Physician (if different from referring physician)**
Name:	Name:
Address:	Address:
Phone/Fax:	Phone/Fax:
MOH Billing Number:	MOH Billing Number:
FHO/FHN Practice: □ yes □ no	FHO/FHN Practice: □ yes □ no