INMEDIC
Pain Management Centres

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Professional Referral Form

Referring MD / Allied Health Professional : _____

MD Billing Number :_____

Office Phone # :_____ **Office Fax # :** _____

Possess valid opiate prescribing license? : □ **Yes** □ **No**

Family Physician: □ **As above** □ **No GP** □ **Other:** _____

Patient Name : _____ **D.O.B:** _____

Patient Phone # : _____ **WSIB Claim# (if applicable):** _____

Patient Health Card #:_____**Version Code:**_____ **Issue Date:**_____

Reason for Referral: _____

_____

_____

_____

_____

Current Medications: _____

_____

_____

* Please provide any imaging and/or other consultation documentation along with this referral.

* **I acknowledge that I will resume care of my patient and potential, recommended opiate prescription from InMedic Pain Management Centres.**

Signature : _____

Name : _____