PARKLAND CHRONIC PAIN CLINIC

Ph: 780-916-1611 | Fax: 780-963-4547

Primary Care Network WESTVIEW

REFERRAL BY PHYSICIAN FORM

Patient Information				
Last Name	First Name	Initial	Male ☐	Female ☐
Address	City/Town	Province	Postal Code	
Phone Number	Fax Number	Email Address		
PHN	DOB (dd/mm/yy)	Occupation		
Diagnosis (please print)				
Previous treatment(s) investigation (specify and include all relevant medical background info and attach if required)		Current medications and dosages		

Reason for Physician Referral (check all relevant)

- ☐ I am uncomfortable with opioid use
- ☐ I'm worried with the level of opioids used
- ☐ I'm worried there is an opioid addiction
- ☐ Disability company wants multi-disciplinary assessment
- ☐ Pain poorly controlled
- ☐ Patient requested referral
- ☐ Parkland Chronic Pain Clinic Outreach Program
- ☐ Needs more services (i.e. psychological)

Referring Physician Information			
Last Name	First name	Initial	Physician PRACID
Address	City/Town	Province	Postal Code
Phone Number	Fax	Email Address	

Please include all available, associated medical documentation with this referral.

Physician signature _____Date _____