Dr. Melissa Holowaty

1 Madoc Street
Marmora, Ontario K0K 2M0
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date:

Referral Form for Chronic Pain Assessment and/or Opiate Tapering

We will contact your patient directly with appointment information as well as letting you know when an appointment has been booked for your patient.

Patient name: _____

Birth date (DD MM YYYY): _____

Health card #: _____Version_____

Address: _____

Phone number: _____

email address : _____

Please attach the following:

- ☐ *Previous assessments by specialists, pain clinics or yourself*
- ☐ *Most recent diagnostic imaging pertinent to pain complaint*
- ☐ *Identified concerns about substance abuse or misuse*

Please notify patient of the following:

- ☐ *Forms will be emailed for completion by the patient prior to an appointment date*
- ☐ *Urine drug screening at the first visit is standard*

Referring physician (please print): _____

Physician OHIP #: _____

Clinic phone #: _____

Referring physician signature: _____

Please send on any other information that you feel to be relevant.