Mooney's Bay Pain Clinic

2847 Riverside Drive
Ottawa ON K1V 8N4
Phone: (343) 224-1344 Fax:
(343)224-1382
www.mooneysbaypainclinic.ca

CHRONIC PAIN REFERRAL FORM

We have Special Practice Exemptions. FHO physicians will not be negated in the RA

Referring MD Name: ______________________ **FHO Practice:** □ **Yes** □ **No**

OHIP Billing Number: __________ **Telephone:** __________ **Fax:** __________

Address: ______________________________

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Family Physician (if different from above): ______________________________

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Patient Name: ______________________ **Date of Birth:** __________

Patient Health Card Number & Version Code: ______________________________

Health Card Expiry: __________ **WSIB Claim Number (if WSIB):** __________

Telephone Number: __________ **Alternate/Emergency Phone:** __________

Address: ______________________________

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Chief Complaint: ______________________________

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Current Medications: ______________________________

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Please attach copies of imaging reports as well as relevant consultations, treatments and surgical notes.

In referring my patient, I acknowledge that I will resume care of my patient after discharge from Mooney's Bay Pain Clinic.

Signature: ______________________ **Date:** __________