The Simcoe Clinic

Physician Referral Form

Referring MD

Name_____Billing Number_____
Address_____
Phone_____Private_____Fax_____

Patient

Name_____Phone_____
Address_____
HCN_____DOB_____
WSIB: Yes No If Yes: WSIB #_____SIN_____

Current Pain Problem / Diagnosis **(**palliative PPS if known - ___%)

Current Treatments (include doses) (CCAC involved ____)

Previously Tried Treatments

Other Past Medical History

PLEASE ATTACH RELEVANT
Lab work, Imaging, EMG/NCS, Consults including Neuro, Neurosx, Ortho, Rheum, Physiatry, Psych, Oncology and Pain.

I acknowledge that I will resume ongoing care of my patient after discharge from The Simcoe Clinic and this may involve prescribing acting opioid medications.

Signature_____Date_____

The Simcoe Clinic
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