Fax/Email to Dr. Joseph Park For Opioid addiction

DATE: _____

TO: Mississauga Pain Clinic

FAX: 905-858-3527
EMAIL: jppainclinic@yahoo.ca

RE: _____

# of Pages including the cover sheet: _____

Notes/Comments:

From Dr. _____
OHIP Billing #: _____

Referral form to Dr. Joseph Park/Mississauga Pain Clinic
for addiction to opioid

Suite 220, 6855 Meadowvale Town Centre Circle, Mississauga, ON, L5N 2Y1
OFFICE: (905) 858-8512, FAX: (905) 858-3527, jppainclinic@yahoo.ca

DATE: _____ PHYSICIAN:_____

PATIENT INFO:
NAME: _____ PHONE: _____

ADDRESS: _____

DOB: _____ HEALTH CARD: _____

HT: _____ WT: _____

REASON FOR CONSULTATION: _____

_____

_____

_____

PLEASE CHECK THE OIPIOID/SEDATIVES ADDICTED

☐ Percocet ☐ Dilaudid ☐ Morphine ☐ Fentanyl

Others: _____

PHARMACOLOGICAL THERAPY

☐ Opioid therapy/weaning

PLEASE CHECK THE DIAGNOSIS

☐ Neck pain ☐ Cervical radicular pain ☐ Low back pain

☐ Lumbar radicular pain ☐ CRPS (RSD) ☐ Other

Your faxed referral will <u>not</u> be processed unless you include:

☐ **Specific questions that you want to ask**

☐ **Pain questionnaire filled out by your patient**

☐ **Previous addiction treatment if any**