

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 #: _____

Confidentiality Note

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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 not be processed unless you include:

- ☐ **Specific questions that you want to ask**
☐ **Pain questionnaire filled out by your patient**
☐ **Previous addiction treatment if any**