



Date of Referral: _____

Chronic Non-Cancer Pain Program

Integrative Pain Program
(Includes non-OHIP services)

- Dr. Richard Nahas**
- First available physician**

Patient Demographics: (complete or affix patient label)

Name: _____ DOB (DD/MM/YY): _____

Telephone: _____ Male Female

Current treatment

Opioids (total daily dose)

- Codeine _____
- Morphine _____
- Oxycodone _____
- Hydromorphone _____
- Fentanyl (µg/h) _____
- Tramadol _____
- Burperorphine _____
- Methadone _____
- Other _____

Non-opioid treatment

- Tricyclics _____
- Anticonvulsants _____
- Antidepressants _____
- NSAIDs _____
- Muscle Relaxants _____
- Acetaminophen _____
- Topical Formulas _____
- Other _____

Non-drug therapy

- | | Current | Previous |
|--|---------|----------|
| <input type="checkbox"/> Injections | _____ | _____ |
| <input type="checkbox"/> Physiotherapy | _____ | _____ |
| <input type="checkbox"/> Acupuncture | _____ | _____ |
| <input type="checkbox"/> Chiropractic | _____ | _____ |
| <input type="checkbox"/> Massage | _____ | _____ |
| <input type="checkbox"/> Yoga | _____ | _____ |
| <input type="checkbox"/> Aquafitness | _____ | _____ |
| <input type="checkbox"/> Exercise | _____ | _____ |
| <input type="checkbox"/> Stretching | _____ | _____ |
| <input type="checkbox"/> Meditation | _____ | _____ |

Clinical History

Please attach all relevant lab results, imaging reports, consultation reports and list of current medications.

Physicians requesting chronic pain consultation agree to resume long-term medical management of patients once a stable regimen has been established. This may include long-term prescribing of opioids.

Physician Name

Clinic Name

Signature

Billing #

Telephone

Fax