CPM
CENTRES FOR PAIN MANAGEMENT
102 – 3481 Dutch Village Rd, Halifax, NS
B3N 2S8
P: 902.463.7857 F: 902.463.7564
http://www.cpmhalifax.ca

Referral Form

All fields must be completed and relevant documents attached.

To be seen by: ___ Dr. John Gills *BSc MD CCFP (EM)*
___ Dr. Paul Doucette *MD CCFP (EM)*
___ First available CPM physician

Referring MD:

MD address:

MSI provider billing number (6 digits):

Fax:

MD phone: Back line:

Patient name: Phone: Work: Cell:

Address: HCN: Exp:

DOB:

WCB case: YES / NO

WCB claim #:

Patient receiving disability benefits: YES / NO

Current pain diagnosis:

How long has the patient had chronic pain?

Current treatments (attach list if insufficient space):

Previous treatments (please check all that apply):

Physio ____ Psychological ____ Nerve block ____ Acupuncture ____ TENS ____ Acetaminophen ___ NSAIDs/COXIBs ___

Tricyclics: _____ Other antidepressants: _____ Cannabinoids: _____

Antiepileptics: Carbamazepine ___ Gabapentin ___ Pregabalin ___ Topiramate ___ others: _____

Opioids: short-acting ___ If long-acting opioids, specify: _____

Multi-disciplinary pain program (where/when) _____

Surgical (what/when) _____

Please attach copies of any relevant investigations/consults:

Investigations: Imaging reports ____ Relevant lab work ____ EMG/NCS ____

Consults: Neuro ____ Ortho ____ Neurosurg ____ Rheum ____ Physiatry ____ Psych ____ Pain ____

I acknowledge that I have read the conditions of referral and will resume care of my patient after discharge from CPM.

Physician signature: _____ Date: _____