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REFERRAL FORM

MULTIDISCIPLINARY TRANSITIONAL PAIN CLINIC & OPIOID TAPER PROGRAM

FAX: (403) 452-0995

Date of Referral: _____

PATIENT & REFERRING PHYSICIAN INFORMATION			
Name			
Address			
Telephone No.		**Cell No.**	
DOB		**PHN**	
Physician		**PRA C ID**	
Phone		**Fax**	

DIAGNOSIS:

PAST HISTORY:

Allergies:

Medical Conditions:

Surgeries:

Smoker: ☐No ☐Yes: Number of packs per week:

Alcohol use: ☐No ☐Yes: Number of drinks per week:

MEDICATION LIST:

Is the patient ≥90 mg of morphine equivalents per day?

☐ Yes ☐ No

*(≥60 mg oxycodone, ≥200 mg codeine, ≥18 mg hydromorphone, ≥25 ug (mcg) of fentanyl).

Have you discussed Opioid Tapering with the patient?

☐ Yes ☐ No