185 Plains Road East, Unit 1&2
Bulington, ON L7R 2T5
Tel: 905-631-9355
Fax: 905-631-1400
www.wellbeings.ca

Dr. Michael Boucher, MD, DCAPM, CIME – Medical Director, Wellbeings®

Dr. Allison Blain, B.Sc, B.Ed, MD, FRCpC – practising in Pain Management and Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD)

Dr. Priyanka Kapil, MD, CCFC, **-** practising in Opioid Use Disorder (OUD), Substance Use Disorder (SUD including AUD and cocaine)

Dr. Linda Korz, B.Sc, MD, LMCC, RCPC Fellow, RCPC (Anesthesia), RCPSC Specialist – Addiction Medicine

Dr. Suneel Upadhye, MD, M.SCm FRCPC – practising in Pain Management

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Referral Request Form – Please Fax to: 905-631-1400 **Please print legibly**

Patient: _____ HCN: _____ VC: _____

Address: _____ City_____

Postal Code: _____ DOB (dd/mm/yyyy)_____

Patient Home Phone:_____ Patient Cell Phone:_____

Referring Physician:_____ CPSO: _____

Billing Referral #: _____ Phone #:_____

Back Line #:_____ Fax #:_____ Email:_____

Address:_____ City:_____ Postal Code:_____

Current Diagnosis:_____

Is there a known history of alcohol and/or drug abuse/addiction? Yes___ No___ Unsure___

Would you like to partner in medical management for opioid use? Yes___ No___

Is the patient currently using opioids? Yes___ No___

Is the patient taking >90mg ME/day? Yes___ No___

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Brief description of any Dependency/Addiction issues if applicable:

_____

_____

Please indicate all previous treatments (check all that apply):

Acetaminophen____ Acupuncture____ Antidepressants____ Cannabinoids____ Counselling ___

Nerve Blocks____ NSAIDS/COXIBs____ Opioids____ Methadone____ Suboxone_____

Other (please specify) _____

Current treatments and medications (please attach an extra page if there is insufficient space):

_____

_____

_____

_____

Please note: Attach all investigations to this referral from when submitting.

The following reports are attached (please check):

Investigations: Imaging Reports___ Relevant Lab Work___ EMG/NCS___ MRI___

Consults: Neuro___ Neurosug___ Ortho___ Pain___ Physiatry___ Psych____ Rheum___

I acknowledge that this patient is currently under my care and I have the authority to make this referral. I acknowledge and have read the conditions of the referral and will resume care of my patient after discharge from Wellbeings, if I am part of a rostered practice.

Please know that if you are the primary physician, no opioids will be prescribed to your patient without your knowledge unless the patient refuses to allow disclosure.

Physician's Signature: _____ Date: _____

The physician is a member of an (please circle): FHO FHT FHG

Total number of pages in this referral are: _____