Referral Form: VON Chronic Pain Program

Referrals accepted via fax or Ocean eReferral Network

Tel: 519-945-2931 | Toll Free: 1-855-419-5200 ext. 4 | Fax: 1-855-492-2963
Windsor-Essex, Chatham-Kent, Sarnia-Lambton
250 Tecumseh Rd E., Unit 190, Windsor ON N8X 2R3

Date: _____

Patient Demographics:
Last Name: _____ First Name: _____ Middle Initial: _____
Health Card #: _____ VC: ____ Gender: M F Non-binary
Date of Birth (mm/dd/yy): _____
Address (Street, Province, PC): _____
Primary Phone #: _____ Secondary Phone #: _____
Email Address: _____

Eligibility: chronic non-cancer pain (longer than 3 months), not considered end of life & patient has consented to referral.

Clinical Information:
Chronic Non-Cancer Pain Diagnosis: _____
Reasons for Referral:

☐ Consult & recommendations for chronic non-cancer pain
☐ Counselling, psychosocial support, Chronic Pain Management Group
☐ Assessment for opioid tapering or opioid rotation *see eligibility below
☐ Assessment for opioid replacement therapy with Buprenorphine/Naloxone (Suboxone) * see eligibility below
☐ Other: _____

History of Chronic Non-Cancer Pain – include duration, interventions, past medication trials:

_____
_____
_____
_____

Please attach cumulative patient profile, diagnostic imaging and consult notes relevant to the chronic non-cancer pain condition.

Referring Agency/Practitioner: _____
Address (Street, Province, PC): _____
Phone #: _____ Fax #: _____
Primary Care Provider (if different from above): _____

This service primarily provides assessment and recommendations; the primary care provider continues to facilitate the overall management of the patient's chronic pain.

*** Eligibility for VON Chronic Pain Program to temporarily prescribe for opioid tapering or opioid rotation:**

1. Patient is experiencing complications of long-term opioid therapy and/or failed attempts at tapering
2. PCP agrees to resume prescriptions once patient is stable
3. Patient is engaged and agrees with plan of care

Signature: _____