Hamilton Health Sciences

McMaster University Medical Centre
4th Floor Yellow Section 4V
1200 Main St. West, Hamilton, ON L8N 3Z5
Phone: (905) 521-7931 Fax: (905) 521-7975
Website: www.hhsc.ca/pain

Michael G. DeGroote PAIN CLINIC

TO: Intensive Program	Date :

The following worker is being referred for:

☐ Chronic Pain Management Interdisciplinary Assessment with Physician, Psychologist and Occupational Therapist (to determine suitability for group program)

****Patients must be able to understand and converse in English, work in groups of people, be cooperative, and be independent in self-care (i.e. dressing, personal care, etc.) to participate in the group program**

Employee #:	DOB:	Male ☐ Female ☐
Surname:	Given Name:	
Address:		
Telephone #:	Email Address:	
Date of Injury:	Recurrence:	

CURRENT STATUS WITH EMPLOYER: ☐ Job Available	☐ Modified Duties Available	
HISTORY OF INJURY:		
EMPLOYER:	Job:	
Address:		Lost Time:
Comments:		

ASSESSMENT AND TREATMENT TO DATE (DETAILS AND DATES)

****If you are initiating this referral based on a recommendation from a physician/specialist or other health professional please indicate whom and include their report with this referral form.** If applicable, Chronic Pain Management recommended by:
Specialist:
Physiotherapy:
Chiropractic:
Other (specify):
MEDICATIONS:

INVESTIGATIONS	**DATE(S)**	**REPORTS INCLUDED**
☐ X-Rays		
☐ MRI		
☐ CT Scan		
Other (specify):		

ADDITIONAL COMMENTS

PRIMARY TREATING PRACTITIONER	**FAMILY PHYSICIAN (IF DIFFERENT)**
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax:	Indicate # of years with family physician:

REFERRAL SOURCE / EMPLOYER CONTACT

Name:	
Office:	
Phone:	Fax:
Email:	

SIGNATURE: _____

PLEASE ATTACH MEDICAL DOCUMENTATION