Cottage Pain Clinic

Mail: 4668 Hwy 518 W.
R.R.#1 Sprucedale, ON
P0A 1Y0

Phone: 705 571 6881
Fax: 705 385 2251
(pre arranged only)

Email: office@cottagepainclinic.com

Physician, Nursing Practioner (NP), Referral Form

Criteria for Referral

- Please review eligibility requirements and frequently asked questions on the website http//:www.cottagepainclinic.com
- Masor® Mobile Treatment is a specialized pain treatment service which currently covers the Muskoka Parry Sound area and is subject to a km rate charges beyond a 25 km radius from its office location.
- Out of area clients may be referred for treatment if visiting and arrangements are confirmed in advance.
- A fee for consultation applies when requested.
- Is not covered under the Ontario Health Insurance Plan.
- A client forms package is completed at time of initial appointment and updated as required for treatment evaluation and follow-up plans.
- A Physician, Nursing Practioner must be actively involved in the patient's care.
- The client's pain condition must be within the generally accepted criteria of chronic back pain.
- The client must be 18 years of age, capable cognitively, and without a mental health condition that would affect her or his ability to receive this specialized treatment.
- Once a completed referral has been received and accepted, treatment fees are paid directly by the client or through a predetermined third party. (Treatment times vary from 30 to 45 minutes per treatment session). Payment is due post session treatment or through third party financial arrangement.
- A report fee applies if requested by a third party and contingent upon consents required. No part of this specialized treatment service is intended for use in legal proceedings and /or medical legal purposes.

Required Information 1

Cottage Pain Clinic - Physician, NP Referral Form

1) Referring Physician, Nursing Practitioner.

Referring MD, NP
Address:
Phone: Fax and email:
Third Party Insurance, Organization Contact
Address of Third Party:
Phone: Fax and email

2) Client Information.

Patient Name
Male Female D.O.B.
Home Address:
Phone:
Cell:
Work Phone
Other Contact:
Email:

Required Information 2

Cottage Pain Clinic - Physician, NP Referral Form

3) Family Physician or Nursing Practitioner

Family Physician, NP
Address:
Phone:
Fax, Email:

4) Clients Related Pain History and Current Chronic Back Pain Problem

Patients pain problem:
Brief Medical History related to problem, including past/current consultations, treatment and outcomes:

Required Information **3**

Cottage Pain Clinic - Physician, NP Referral Form

5) List of Current Medications

6) Additional Comments

7) Referring Physician, NP Acknowledgements

I, as referring MD, NP, do acknowledge that all information is complete and this referral meets the conditions Cottage Pain Clinic has set out for this specialized treatment service. I continue to be actively involved with this patient's care and have relayed the necessary referral information to your patient and any other third party requirements.

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Signature Date

This completed referral can be mailed to the Cottage Pain Clinic office address above or in special circumstances to our fax # that must be pre arranged through calling our office. Most referrals are received via mail within 5 days. Wait times indicated on our website usually apply once a referral has been accepted. Thank you for your referral.