



**REFERRAL TO
COMOX VALLEY NURSING CENTRE
Community Pain Service Support
615 Tenth Street, Courtenay BC V9N 1R2
Tel: 250.331.8502 Fax: 250.331.8503**

DATE: _____
 CLIENT NAME: _____ PHONE #: _____
 CLIENT ADDRESS: _____
 D.O.B. _____ PHN#: _____

ATTN: DROP IN NURSE OF THE DAY

REASON FOR REFERRAL:

DIAGNOSIS AND MEDICAL HISTORY:

DIAGNOSTIC TESTS/SPECIALIST CONSULTATIONS: **PLEASE ATTACH**

MEDICATIONS:

Referral for the following: (double click on box and select check or not checked)

- | | |
|--|---|
| <input type="checkbox"/> Individual Health Consultation with Primary Care Nurse | <input type="checkbox"/> Chronic Pain Support Group |
| <input type="checkbox"/> GP Pain Consultation (<i>Must be seen by Primary Nurse first</i>) | <input type="checkbox"/> Good Vibrations Relaxation Therapy Program |
| <input type="checkbox"/> Chronic Pain Mgt. Team (<i>Must be seen by Primary Nurse first</i>) | <input type="checkbox"/> Super 7 Exercise Program |
| <input type="checkbox"/> Chronic Pain Educational Series | <input type="checkbox"/> Links with other community services and agencies |

Has client/patient been informed of this referral? Yes No

REFERRED BY: _____ PHONE #: _____

CLINIC OR AGENCY: _____