

Physio /Chiro / Osteo Referral Form

18 YEARS OF AGE OR OLDER

Health Care Provider Information:

(Name, Telephone, Fax number, Address, Email)

Patient Information:

(Name, Date of Birth, Health Card, Telephone & Address)

Please select the preferred clinic for your patient:

Toronto Mississauga Brampton Scarborough Oshawa London Ottawa Hamilton

Primary complaint: _____

Treatment provided: _____

Mechanical concern addressed? Y N

Duration of pain complaint: _____

Is the patient on blood thinners? Y N

Has the patient tried Botox? Y N

Patient's Family Doctor Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

- Patient advised to make Family Doctor aware of referral to NeuPath, Centre for Pain & Spine. Consultation reports will be sent to both the referring provider and the family doctor.
- Patient advised that referral to NeuPath, Centre for Pain & Spine is only for interventional treatment of their pain. If assessment of any other pain is required, a referral from the Family doctor will be required.

Provider Signature: _____ **Date:** _____
Provider type: _____