NeuPath
Centre for Pain & Spine

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:

☐ 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: _____

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FAX REFERRALS TO 1-877-883-3301 CALL TOLL FREE 1-800-265-3429 ext 1022

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