HealthPointe
Centre for Pain, Spine & Sport BY NEUPATH

GENERAL REFERRAL FORM

Referring Physician Information (may stamp):

Clinician Name:
Address:
Phone Number:
Fax Number:
PRAC ID:
Email:

Patient Information (may attach label):

Patient Name:
Date of Birth:
AHC#:
Address:
Phone(H):
Phone(C):
Email:

Physician Requested:

☐ Next available
☐ Specific Physician (Please specify including reason for request):

_____

Clinical Question/Concern:

Is this related to WCB injury/claim?	Y☐	N☐
Is this related to MVA?	Y☐	N☐
Any active mental health issues?	Y☐	N☐
Any history of substance abuse?	Y☐	N☐
Any form of income support?	Y☐	N☐
Are you able to maintain a narcotic RX?	Y☐	N☐

Please list any relevant details:
WCB Claim# _____
Date of injury: _____

Pertinent History & Physical Examination:

If possible, please provide the following with your referral:

☐ List of current medications, allergies, other medical conditions and previous surgeries
☐ Prior assessments, investigation, treatments and/or other relevant information

An incomplete referral form will be sent back to the referring clinician for completion

An intake assessment may be required prior to access some of the listed clinic services.

Suite 301, 575 100 Street SW Edmonton, AB
FAX REFERRALS TO 780.453.9099 CALL 780.453.5255
neupath.com