

PHYSICIAN REFERRAL FORM

18 YEARS OF AGE OR OLDER

Patient email: _____

Health Care Provider Information:

Name, Address, Phone, Fax, Billing #

Patient Contact Information:

Name, Address, DOB, Health Card, Phone

Physician email: _____

Please select the preferred clinic location:

London Hamilton Mississauga Brampton Toronto Scarborough Oshawa Ottawa

Referring Provider:

Primary Care provider Specialist other _____

Primary Pain Diagnosis: _____ Secondary Diagnosis: _____

Length of Pain Complaint: _____

Is the patient on blood thinners? Y N If yes, please specify: _____

Is this referral for Lidocaine infusions (Oshawa only) Botox Viscosupplementation

To expedite the referral please provide:

- Patient's Medical History/ Copy of Cumulative Patient Profile
- Relevant imaging/consultation/operative reports
- List of current medications

I acknowledge that I am sending the patient for consultation and possible treatments and I agree to resume care for this patient after discharge.

Health Care Provider Signature: _____ Date: _____