NeuPath
Centre for Pain & Spine

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 ☐ 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:_____

6400 MILLCREEK DRIVE, UNIT 9 · MISSISSAUGA ON. L5N 3E7 · T 905.288.1022 · F 905.858.0111

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

neupath.com