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: ____________________