



# UNIKA

MEDICAL CENTRE

647-740-1429  
905-597-8994  
info@unikamed.com

240Duncan Mill Rd Unit 800  
North York Ontario M3B 3S6

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

HCN: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_ Phone: \_\_\_\_\_

SERVICE REQUESTED:  Consultation  Procedure  Multidisciplinary Care

Other: \_\_\_\_\_

### REASON FOR REFERRAL:

- Headache
- Facial/TMJ Pain
- Neck Pain
- Back Pain
- Fibromyalgia
- Post-Surgical/Trauma Pain
- Peripheral Neuropathy
- OA/MSK Pain
- Oral Pain

Other: \_\_\_\_\_

INSURANCE:  Personal Injury  WSIB  Extended Benefits  OHIP  Other

MEDICAL / PSYCHIATRIC HISTORY:  ATTACHED

- CV
- OA/RA
- OSA
- COPD
- PVD
- Mental Disorder
- Stroke/TIA
- Diabetes
- Substance Abuse

SURGICAL / TRAUMA HISTORY:  ATTACHED

- Was operated to treat pain
- Pain appeared after surgery / trauma

MEDICATIONS:  ATTACHED

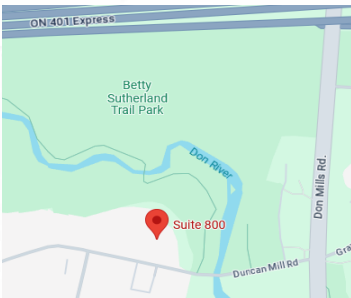
- Anticoagulant / Antiaggregant
- Medicinal Cannabis
- Opioids
- Anticonvulsant / Antidepressant
- Benzodiazepines
- OTC

PREVIOUS TREATMENTS:  ATTACHED **[please send pertinent records]**

- Medications
- Injections
- Multidisciplinary
- Allied Health
- CAM

### SOCIAL HISTORY:

Employed  Unemployed  Disability  Retired  Other \_\_\_\_\_



Referring MD \_\_\_\_\_

Billing#: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_