



Patient's First Name _____

Last Name _____

HCN: _____ D.O.B. _____

Address _____

Home Phone: _____ Alternative Phone: _____

SERVICE REQUESTED: Consultation Procedure Multidisciplinary Care

Other: _____

REASON FOR REFERRAL:

- Headache Nerve Injury Neck Pain
- Back Pain Fibromyalgia Post-Surgical/Trauma Pain
- Peripheral Neuropathy OA/MSK Pain Regenerative Medicine

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