UNIKA MEDICAL CENTRE
647-740-1429
905-597-8994
support@unikamed.com
20 De Boers Drive,
Unit 207, Toronto, ON,
M3J 0H1

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