

# REFERRAL FORM

**Toronto**  
15 Wellesley Street W Suite 301  
Toronto, ON | M4Y 0G7  
Tel: 416 – 413 – 7999  
Fax: 416 – 641 – 4520  
Parking available on site.

**Hamilton**  
554 John Street N  
Hamilton, ON | L8L 4S1  
Tel: 905 491 7597  
Fax: 289 408 5118  
Free Parking available on site.

We are specialized in image-guided interventional pain management strategies, offering multidisciplinary pain management services.

## PATIENT INFORMATION

Name: \_\_\_\_\_ OHIP: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

## PROVIDER INFORMATION

Referring Provider: \_\_\_\_\_ Billing Number: \_\_\_\_\_  
Fax/Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_

WSIB  MVA

## REASON FOR REFERRAL

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## TYPE OF ASSESSMENT (NO NEGATION TO FHO/FHT)

Comprehensive Pain Consult

Interventional Pain Referral

Sports Medicine Consultation

Specific Procedure / Intervention: \_\_\_\_\_

Group Pain Classes

Medication Management

Urgent Assessment: \_\_\_\_\_

Specific Pain Physician: \_\_\_\_\_

Please include all pertinent imaging within the last 2 years.

Baseline ECG is required for patients being referred for infusion therapy.

