REFERRAL FORM

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

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

☐ **Scarborough**
520 Ellesmere Road
Unit 115
Toronto, ON | M1R 0B1
Tel: 416-925-3730
Fax: 647-947-6507
Parking available on site.

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

PATIENT INFORMATION

Name: _____
Date of Birth: _____
Address: _____
OHIP: _____
Phone: _____
Email: _____

PROVIDER INFORMATION

Referring Provider: _____
Fax/Email: _____
Primary Care Provider: _____
Billing Number: _____
Phone: _____

REASON FOR REFERRAL

☐ WSIB ☐ MVA

_____
_____
_____

TYPE OF ASSESSMENT (NO NEGATION TO FHO/FHT)

☐ Comprehensive Pain Consult
☐ Interventional Pain Referral
☐ Sports Medicine Consultation
☐ Specific Procedure / Intervention: _____
☐ Pain Pyschiatry and Psychology
☐ 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.

Referrals also available via: OceanMD A WELL Health Company

www.AfiyaPainClinic.ca