Referral Form for Chronic Pain Management
Please fax completed form to: **(647) 670-0409**

Patient name:	Patient phone number:
DOB (DD/MM/YY):	OHIP (incl version code):
Patient Address:	
Referring physician:	Physician signature:
Office phone number:	Billing number:

Select location:

☐	☐	☐	☐
801 Eglinton Ave W, Suite 100 Toronto, M5N1E3	7155 Woodbine Ave, Suite 106 Markham L3R1A3	2000 Credit Valley Rd, Suite 405 Mississauga L5M 4N4	2737 Keele St, Suite 20 Toronto, M3M 2E9

Reason for referral:

**Exclusion criteria: Cancer Pain, <18 years old, urgent/emergent cases, addiction, poorly controlled mood disorders, Pain <3 months in duration.

Previous investigations (please attach reports):	Previous treatments (eg. epidural, rhizotomy, nerve block, trigger points, steroid injections, surgical, other):
Current medications:	
Previous specialists/practitioners seen for pain:	

Incomplete referrals will be returned. Appropriate care will resume once one of our physicians have seen the patient. Some services are not covered under OHIP (your patient will be informed if required).