Vireo Pain Clinic

PATIENT REFERRAL FORM

Patient Information

Patient Name: _____
Date of Birth: _____
Health Card Number: _____
Phone Number: _____
Address: _____

Reason for Referral:

☐ Low Back Pain / Sciatica
☐ Cervical / Thoracic Back Pain
☐ Headache
☐ Fibromyalgia
☐ Neuropathic Pain
☐ Other (specify) _____

Duration of Pain: _____ ☐ Weeks ☐ Months ☐ Years

History of Substance/Alcohol Abuse: ☐ Yes ☐ No

Current Medications:

Anti-coagulation agents: ☐ Yes ☐ No

Additional Information/Documentation:

Please include all relevant investigations, imaging, blood-work & consultation reports.

Referring Physician

Name: _____
Specialty: _____
Phone: _____
Fax: _____
MOH Billing Number: _____
FHO/FHN Practice: ☐ Yes ☐ No

Address: Suite 212 - 50 McIntosh Drive, Markham, Ontario L3R 9T3
Tel: (647) 371-1906 | **Fax:** (647) 255-5335
Email: hello@vireopainclinic.com | **Website:** www.vireopainclinic.com