



**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) 340-6093 | **Fax:** (647) 255-5335

**Email:** hello@vireopainclinic.com | **Website:** www.vireopainclinic.com