Altara MD

10 Neighbourhood Lane, Suite 103, Etobicoke ON M8Y 0C5
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Place patient label here

Place physician stamp here

PAIN CLINIC | REFERRAL FORM

Note: We do not negate FHN/FHO billing of referring providers.

Per CPSO Policies, all consultation requests must include: Reason for referral | Urgency | Relevant medical history | Current medications | All relevant test and procedure results. Incomplete referrals will result in a delay in patient care.

PHYSICIAN INFORMATION

Referring MD: _____ Billing No.:_____ ❒ FHO ❒ FHN ❒ Other: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Family MD *(If different from referring MD)* Name: _____ Fax: _____ Phone: _____

PATIENT INFORMATION

Health Care No.: _____ Version Code: _____ Expiry Date:_____

Name: _____ DOB:_____

Address: _____

Main Phone: _____ Alternate Phone: _____

REASON FOR REFERRAL

Pain Diagnosis (if known): _____

Duration of Pain: ❒ Less than 3 months ❒ 3-6 months ❒ More than 6 months | ❒ Urgent ❒ Standard

PAIN DETAILS

❒ Cervical spine
❒ Headaches/Migraine
❒ Lower back pain with radiculopathy
❒ Lower back pain without radiculopathy
❒ Shoulder pain
❒ Generalized body pain
❒ Other: _____

Past treatment history:

_____
_____
_____

Desired outcome:

_____

Patient is interested in nerve blocks: ❒

Please enclose:

❒ *Complete medication list*
❒ *Medical records pertinent to chief complaint.*

Investigations attached:
❒ MRI ❒ X-Ray ❒ Ultrasound ❒ CT ❒ EMG/NCS

History of drug/alcohol abuse/addiction? ❒ Yes ❒ No
(If yes, relevant substance(s)): _____

Please return by **Fax: (416) 572-8727** or **E-mail: referrals@altaramd.ca**