NeuPath
Centre for Pain & Spine

# PRACTITIONER REFERRAL FORM

18 YEARS OF AGE OR OLDER

**Patient Email:** _____

**Health Care Provider Information:**
Name, Phone, Fax, **Billing #** ☐ FHO ☐ FHT

**Patient Information:**
Name, Address, DOB, Health Card, Phone

**Please Select Preferred Clinic Location(s):**

☐ London ☐ Hamilton ☐ Mississauga ☐ Brampton ☐ Scarborough ☐ Oshawa ☐ Ottawa

**Referring Provider:**

☐ Family MD / NP ☐ Specialist ☐ Dentist ☐ Chiropractor ☐ Physiotherapist ☐ Osteopath ☐ Other: _____

**Primary Pain Diagnosis, Region of Pain & Length of Complaint:**

_____

_____

_____

| To expedite the referral please select the treatments / services: | Please provide: |
|---|---|
| ☐ Chronic Pain Management Assessment<br>☐ Botox Injections<br>☐ Viscosupplementation (Knee)<br>☐ Arthrosamid (Knee)<br>☐ Perineural Injection Therapy (PIT)<br>☐ Prolotherapy<br>☐ Radiofrequency Ablation (RFA)<br>☐ Platelet Rich Plasma (PRP)<br>☐ Lidocaine Infusions *(Mississauga & Oshawa Only)*<br>☐ Ketamine Infusions *(Mississauga & Oshawa Only)*<br>☐ Fluoroscopy *(Mississauga & Ottawa Only)* | ☐ **Patient's Medical History / Copy of Cumulative Patient Profile**<br>☐ **Relevant Imaging / Consultation / Operative Reports**<br>☐ **List of Current Medications** |

☐ I recognize that my patient is being referred into an interdisciplinary program, and when indicated will receive care from allied healthcare professionals in addition to care from a physician with pain expertise.

☐ ***If you are not*** the Primary Care Practitioner or Specialist, please have your patient advise PCP of the referral to NeuPath Centre for Pain & Spine. Consultation reports will be sent to the referring practitioner and / or PCP.

☐ Practitioners other than Primary Care Practitioners and Specialists acknowledge the patient has been advised this referral is only for interventional treatment. If assessment of any other pain a referral from PCP will be required.

**Name of PCP:** _____ **Fax #:** _____

☐ I acknowledge that I am sending the patient for consultation and possible treatments and I agree to resume care for this patient after discharge.

**Health Care Provider Signature:** _____ **Date:** _____