

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 ☐ Guelph ☐ 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:

- ☐ Pain Management Assessment
- ☐ Botox Injections
- ☐ Viscosupplementation (Knee)
- ☐ Arthroamid (Knee)
- ☐ Perineural Injection Therapy (PIT)
- ☐ Prolotherapy
- ☐ Platelet Rich Plasma (PRP)
- ☐ Lidocaine Infusions (Mississauga & Oshawa Only)
- ☐ Ketamine Infusions (Mississauga, Oshawa, Ottawa Only)
- ☐ Fluoroscopy (Mississauga, Oshawa, Guelph, Ottawa Only)
- ☐ Radiofrequency Ablation (RFA) (Mississauga, Oshawa, Guelph, Ottawa Only)
- ☐ Sports Medicine (Brampton, Scarborough, Oshawa, Ottawa Only)
- ☐ Vitamin Infusions (Ottawa Only)

Please provide:

- ☐ Patient's Medical History / Copy of Cumulative Patient Profile
- ☐ Relevant Imaging / Consultation / Operative Reports
- ☐ List of Current Medications

Omission of the required materials will result in the referral being returned to you

- ☐ 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: _____