PREMIER PAIN INSTITUTE

865 York Mills Rd. Suite 20
Toronto, ON, M3B 1Y6
P: 647.477.7050
F: 647.477.7056
E: info@premierpain.ca

PATIENT REFERRAL FORM

☐ URGENT
(SPECIFY REASON)

Patient Information

Name:

Gender: ☐ M ☐ F ☐ Other

Address:

P: Email:

☐ OHIP ☐ Private ☐ MVA

☐ WSIB ☐ Refugee

OHIP# VC: Exp.:

DOB:

Referring Physician

Physician Name:

Address:

Email:
T: F:

Billing #:

CC Family Doctor (please enter name):

Please write clearly

Diagnosis:

Clinical history:

Consultation for the following:

☐ Interventional pain MD consult ☐ Request for specific procedure

Supporting information:

To assist in timely and accurate care, please include all relevant information and attach supporting prior consultation notes and imaging reports. Thank you.

Current relevant medications:

Investigations to date:

☐ MRI ☐ X-Rays ☐ CT ☐ EMG/NCV

☐ US ☐ Bone scan

Physician signature:

Date: