NeuPath
Centre for Pain & Spine

REFERRAL FORM

18 YEARS OF AGE OR OLDER

Patient email Address: ______________________________

Health Care Provider Information:

Name, Address, Phone, Fax

Patient Contact Information:

Name, Address, DOB, Health Card, Phone

Physician email Address: ______________________________

Please select the preferred clinic location:

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

Referring Provider:

☐ Primary Care provider ☐Specialist ☐ other ______________

Primary Pain Diagnosis: ______________ Secondary Diagnosis: ______________

Length of Pain Complaint: ______________

Is the patient on blood thinners? Y ☐ N ☐ If yes, please specify: ______________

Is this referral for ☐ Lidocaine infusions (Oshawa only) ☐ Botox ☐ Viscosupplementation

To expedite the referral please provide:

- ☐ Patient's Medical History/ Copy of Cumulative Patient Profile
- ☐ Relevant imaging/consultation/operative reports
- ☐ List of current medications

Health Care Provider Signature: ______________ Date: ______________

Billing # (if applicable) ______________