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UNIVERSAL Interventional Pain Clinic

New Patient Referral Form

PLEASE FAX THIS FORM TO: 416-256-0602

Patient Information

Name _____
OHIP No. _____
D.O.B. _____
Address _____
Phone (Home) _____
Cell _____

Referring Physician

Name _____
Billing No. _____
Address _____
Phone _____ Fax _____

Indication(s) for referral

____ Neck Pain (Cervical)
____ Mid Back Pain (Thoracic)
____ Lower Back Pain (Lumbar)
____ Complex Regional Pain Syndrome (CRPS/RSD)
____ Nerve Pain
____ Neuralgia/Neuropathy/Diabetic Neuropathy/Periphera; Neuropathy
____ Radiculopathy
____ Sacroiliac Pain
____ Phantom Limb Pain
____ Upper extremity Joint pain (eg. Shoulder, elbow, wrist, ngers)
____ Lower extremity Joint pain (eg. Hip, knee, ankle, toes)
____ Headaches
____ Facial Pain/Scalp Pain
____ Chest / Abdominal / Groin pain
____ Chronic pain syndrome (eg. Fibromyalgia)
____ Other Pain Condition(s): _____

Medical History

____ Angina
____ Arrhythmia
____ Hypertension
____ Stroke
____ CHF
____ Pacemaker
____ Other Cardiac Disease
____ Allergies

Current Medications _____

____ Please include the following information with this referral form for expedited scheduling:
____ Recent History/Physical or last several office notes
____ A recent copy of the MRI/CT scans or X-Ray reports if available

Please Fax completed form to Universal Interventional Pain Clinic. The Clinic will contact the patient to schedule an appointment to assess, help manage and treat the patient.

Date _____ Signature _____