PAINLESS MEDICINE AND THERAPEUTICS
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PATIENT INFORMATION

LEGAL NAME (AS APPEARS ON HC) _____ PREFERRED NAME _____ DATE OF BIRTH (YYYY/MM/DD) _____

ADDRESS _____

PHONE NUMBER _____ EMAIL ADDRESS _____ HEALTH CARD NUMBER _____ (VC)

REFERRING PHYSICIAN INFORMATION

FIRST NAME AND LAST NAME _____ OHIP BILLING NUMBER _____ FAMILY PHYSICIAN (IF DIFFERENT) _____

ADDRESS _____

FAX NUMBER _____ PHONE NUMBER _____ EMAIL ADDRESS _____

MEDICAL INFORMATION

Reason for Referral

_____

_____

❑ Chronic Pain Assessment ❑ Ketamine Infusion ❑ rTMS ❑ Stellate Ganglion Block

Current Medications

_____

_____

Please attach copies of any relevant imaging reports, consultations, treatments, or surgical notes.

In referring the patient, I acknowledge that I will resume care of my patient after discharge from the Painless Medicine and Therapeutics Clinic.

SIGNATURE _____ DATE _____

COMPLETED FORMS CAN BE FAXED OR EMAILED TO INFO@PAINLESSMEDICINE.CA