REFERRAL FORM

Please complete and Fax to: 705-759-4835

Referral Category: ❑ Sports Medicine ❑ Pain Management
Referral Urgency: ❑ Elective ❑ Urgent ❑ Stat*

***IMPORTANT: DO NOT PUT SEE ATTACHED IN ANY FIELD. FORM MUST BE COMPLETED FULLY OR IT WILL BE REJECTED.*

Patient Demographics		
Patients Name	**Health Card Number**	
Address	**Phone No**	**Alternate Phone No**
City	**Postal Code**	**Date of Birth**

Patient Information	
Provisional Diagnosis:	
Current Medications *DO NOT PUT SEE ATTACHED OR REFERRAL WILL BE	Allergies REJECTED
What pain management interventions were attempted prior to referral? Did this intervention fail? ❑ yes ❑ no	
Please select the appropriate request: ❑ Please assess and provide recommendations on care ❑ Please assume care for the patient for the above diagnosis	

NOTE: Please attach the last six months of diagnostic tests including x-rays, MRIs, CTs, blood work and other pertinent information to assist in speeding up your patients referral process.

Referring Providers Name: ____________________________________

Referring Providers Billing Number: ____________________________

Referring Providers Fax Number: ______________________________

Referring Providers Signature: ________________________________

*we will make every attempt to see the patient as soon as possible based on the triage priority of the office when the referral is received. Any emergency should be referred to the nearest hospital.