Centre for Pain Care
SILVER MEDICAL GROUP

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www.silverpaincare.com

Interventional Pain Management Consultation - Referral Form

Please complete this form and fax it to 416-512-6375 and we will contact the patient directly.

Physician Information Billing #_____ Circle if appropriate: FHN / FHO

Name: [Last, First]_____

Address:_____

Phone:_____ Email:_____ Are you the patient's FP? Yes / No

Fax:_____ Website:_____ Specialty:_____

Patient Information Health Card#_____ Date of Birth: _____

Name: [Last, First] _____

Address:_____

Home Phone:_____ Cell Phone_____

CIRCLE appropriate: OHIP / PRIVATE INS / ODB / ODSP / OTHER

CIRCLE: Is complaint result of **WSIB** or **MVA**?

Date of loss:[MM/DD/YY]_____ Claim#_____

CHIEF PAIN COMPLAINT, CAUSE, CHRONICITY, QUERY: **FACE HEAD NECK BACK OTHER**	**FOR EXPEDITED SERVICE, THIS REFERRAL INCLUDES RESULTS / REPORTS OF:**
	☐ XRAY ☐ MRI ☐ CT SCAN ☐ EMG ☐ US ☐ GFR ☐ OTHER _____ ☐ WRITTEN PERMISSION TO STOP BLOOD THINNERS FOR PROCEDURES IF APPLICABLE ☐ SPECIALIST REPORT ☐ FULL PATIENT SUMMARY
	PLEASE CHECK APPLICABLE:
	☐ H/O DEPRESSION/ PSYCHIATRIC D/O? ☐ ON BLOOD THINNERS? ☐ ON CHRONIC OPIOID TX? ☐ H/O SUBSTANCE USE/ABUSE? ☐ H/O SURGICAL INFECTION? ☐ ALLERGY TO CONTRAST DYE? ☐ H/O CKD?
Referring physician signature:	

PLEASE NOTE, OUR CENTER SPECIALIZES IN ADVANCED **INTERVENTIONAL PROCEDURES**. SEE OUR WEBSITE FOR DETAILS www.silverpaincare.com