

The Scarborough Chronic Pain & Migraine Clinic

Patient Demographics:

First Name: _____ Last Name: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ OHIP: _____ VC: _____

E-mail Address: _____

Referring Physician:

DR. : _____ Billing # : _____

Tel : _____ Fax : _____

Address : _____

*Please indicate if your clinic is affiliated with: FHO FHT FFS

Referring to : First Available Pain Specialist

Dr. Mark D'Souza MD, CCFP

Dr. Kevin Grant MD, FRCSC

Dr. David D'Souza MD, CCFP

Dr. Gilbert Yee MD, FRCSC

Dr. Ken Fern MD, FRCSC

Dr. Pervez Ali MD, FRCS

Dr. Frederick Ma MD, CCFP

Dr. Wilfrid Chan MD, CCFP

REASON FOR REFERRAL

Chronic Neck Pain

Arthritis of the Neck

Chronic Back Pain

Cervical and Lumbar Radiculopathy

Chronic Headaches

Fibromyalgia

Chronic Migraines

Tension Headaches/ Cluster Headaches

Whiplash Injuries

Other

PLEASE FAX REFERRALS TO 416-412-0101- PLEASE BE SURE TO INCLUDE ALL RELEVANT/RECENT IMAGING REPORTS. PLEASE NOTE IN ORDER TO BOOK PATIENTS IN A TIMELY MANNER – ADDITIONAL INFORMATION IS REQUIRED. *We will contact the patient directly to book an appointment*

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thechronicpainandmigraineclinic.com