REFERRAL FORM

The Toronto Chronic Pain and 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. Pervez Ali MD, FRCSC**
- ¤ **Dr. Munir Muhsin MD, MBCHB, CCFP**
- ¤ **Dr. Frederick Ma MD, CCFP**
- ¤ **Dr. Calvin Chan MD, CCFP**

REASON FOR REFERRAL

- ☐ Chronic Neck Pain
- ☐ Chronic Back Pain
- ☐ Chronic Headaches
- ☐ Chronic Migraines
- ☐ Whiplash Injuries
- ☐ Arthritis of the Neck
- ☐ Cervical and Lumbar Radiculopathy
- ☐ Fibromyalgia
- ☐ Tension Headaches/ Cluster Headaches
- ☐ Other

PLEASE FAX REFERRALS TO 416-364-4423- 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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