

**Ataraxia Pain Management Clinic Consultation – Referral Form**

Please complete this form and fax it to 416-221-0585 and we will contact the patient directly.

Date: \_\_\_ / \_\_\_ / \_\_\_  
month / day / year

Patient's Name: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_  
month / day / year

Patient's (Home) Phone #: \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Patient's OHIP #: \_\_\_\_\_ WSIB #: \_\_\_\_\_ M [ ] F [ ]

**Reason for Referral – Please select all that apply**

[ ] Medical consultation - opinion only Details: \_\_\_\_\_

[ ] Medical consultation and treatment Preliminary Diagnosis: \_\_\_\_\_

[ ] Spinal injection: (specify) \_\_\_\_\_

[ ] IV Lidocaine Infusion

[ ] Other injection: (specify) \_\_\_\_\_

[ ] Aided health provider: (specify request)

[ ] Psychotherapy/Psychology

[ ] Osteopathy

[ ] Chiropractic (including acupuncture)

[ ] Nutrition

[ ] Massage

[ ] Naturopathy

[ ] Urgent appointment request: (reason) \_\_\_\_\_ [ ] Telephone [ ] Consult [ ] E-Consult

Preliminary diagnosis: [ ] Back pain [ ] Neck pain [ ] CRPS [ ] Neuropathic pain

[ ] Other pain: \_\_\_\_\_

**Please provide us with the following information:**

- Pertinent medical records including any MRI, CT, x-ray, NCS/EMG, bone scan or lab reports
- Copy of relevant consultations or prior treatment
- Current medications and allergies
- Current medical conditions
- **Additional Comments / Information:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Referring Physician's Name

\_\_\_\_\_  
Ref. Physicians's Signature

\_\_\_\_\_  
OHIP provider #

Referring Physician's Phone: \_\_\_ - \_\_\_ - \_\_\_\_\_ Fax: \_\_\_ - \_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_