ATARAXIA
PAIN MANAGEMENT CLINIC

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Phone # 416-221-1061 Fax # 416-221-0585
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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 heath 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: _____