



8920 Woodbine Avenue, Unit 102, Markham, Ontario, L3R 9W9

**Phone |** (905) 305-9484 **Website |** jacobspaincentre.com

**Fax |** (905) 305-7381 **Email |** admin@jacobspaincentre.com

# Patient Referral Form

## Physician Information

Referring MD:  Billing Number:   
Address:   
Phone:  Fax:  Email:

## Patient Information

Patient HCN:  Version Code:  Expiry Date:   
Patient Name:  Date of Birth:  /  /  (mm/dd/yyyy)  
Address:   
Phone:  Alternative Phone:  Email:

## Reason for Referral

Low Back Pain  Neck Pain  Headaches / Migraines  Shoulder Pain  Neuropathic Pain  Knee/Joint Pain  
 Post-Surgical Pain  Fibromyalgia / Widespread Pain  CRPS Other:

## Specific Service Requested (If Known):

Consultation  Ultrasound-guided Nerve Block  Ketamine Infusions for Pain  Ketamine Infusions for MDD / PTSD  
 PRP  Migraine Treatment  Steroid Injections Other:

## Clinical Information

Pain Duration:   
History of substance/alcohol abuse: Yes  No    
Relevant Medical History:   
  
Current Medications:   
  
Previous Treatments & Responses:   
  
Additional Information:

## Attachments

Consultation and/or treatment notes  Test results  Imaging reports (MRI / CT / X-ray)  Medication List  Other relevant reports

Please complete the above information and fax to (905) 305-7381, or e-mail securely to admin@jacobspaincentre.com.