PAINLESS MEDICINE AND THERAPEUTICS
55 York Street | Suite 601
Toronto, Ontario
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PATIENT INFORMATION

FIRST NAME AND LAST NAME ______________________

DATE OF BIRTH (YYYY/MM/DD) ______________________

HEALTH CARD NUMBER (VC) ______________________

ADDRESS ____

PHONE NUMBER ______________________

EMAIL ADDRESS ______________________

EMERGENCY CONTACT ______________________

REFERRING PHYSICIAN INFORMATION

FIRST NAME AND LAST NAME ______________________

OHIP BILLING NUMBER ______________________

FAMILY PHYSICIAN (IF DIFFERENT) ______________________

ADDRESS ____

FAX NUMBER ______________________

PHONE NUMBER ______________________

EMAIL ADDRESS ______________________

MEDICAL INFORMATION

- ❑ Headache/Migraines
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Low Back Pain
- ❑ Extremity Pain
- ❑ Fibromyalgia

OTHER ____

Current Medications

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Please attach copies of any relevant imaging reports, consultations, treatments, or surgical notes.

In referring the patient, I acknowledge that I will resume care of my patient after discharge from the Painless Medicine and Therapeutics Clinic.

SIGNATURE ______________________

DATE ______________________

COMPLETED FORMS CAN BE FAXED OR EMAILED TO INFO@PAINLESSMEDICINE.CA