EGLINTON
PAIN CLINIC

1643 Eglinton Avenue West
Toronto, ON M6E 2H1
T: 416-943-9090 | F: 416-943-9091

Patient Information **Referring Physician:**

Name:	**Name:**
DOB:	**MOH #:**
Health Card #: **VC:**	**Phone #:**
Phone #:	**Fax #:**
Address:	**Specialty:** **FHO/FHT:** □
	Billing Number:

Reason for Referral: _____

Area of Concern:

□ Low Back Pain / Sciatica

□ Cervical/Thoracic Back Pain

□ Fibromyalgia

□ Neuropathic Pain

□ Headaches

□ Other: _____

Duration of Pain:

_____ □ weeks □ months □ years

History of Substance/ Alcohol Abuse:

□ Yes □ No

Past Headache Medications Used:

_____

_____

_____

Past Medical History:

_____

_____

Allergies: NKDA or _____

To expedite referral processing please include relevant investigations, consultations, and imaging reports.