DANFORTH
PAIN CLINIC

1324 Danforth Avenue
Toronto, ON M4J 1M9
T: 416-849-2230 | F: 416-849-2231

Patient Information **Referring Physician:**

Name:	**Name:**
DOB:	**MOH #:**
Health Card #: **VC:**	**Phone #:**
Phone #:	**Fax #:**
Address:	**Specialty:** **FHO:** □ Yes □ No
	Billing Number:

Reason for Referral:

□ Low Back Pain / Sciatica

□ Cervical/Thoracic Back Pain

□ Headache

□ Fibromyalgia

□ Neuropathic Pain

□ Other: _____

Duration of Pain: _____ □weeks □ months □ years

History of Substance/Alcohol Abuse: □ yes □ no

Current Medications: Anti-coagulation agents: □ Yes □ No

Additional information/Documentation:

_____

_____

_____

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