Toronto Interventional Pain Clinic

www.torontointerventionalpainclinic.ca

CHRONIC PAIN MANAGEMENT REFERRAL FORM

1600 Steeles Ave. W. Unit 19 and
20 Concord ON L4K 4M2
Tel: (905) 738-9990
Fax: (905) 760-9192

Patient Name :	Phone number:
Date of birth (DD/MM/ YY):	OHIP card number:
Patient address:	
Referring physician: Billing Number:	Signature:
Address:	Phone number: Fax number:
Reason for Consultation:	
Past Medical History, Allergies (contrast?), last A1C, **anticoagulation/ antiplatelet status**:	
Previous Investigations (x-ray, CT, MRI, U/S, DEXA, EMG, Bone scan, ETC – imaging does not preclude the patient from procedures):	

PLEASE INDICATE FLUOROSCOPY PAIN TREATMENT REQUESTED

LOWER BACK PAIN (SPONDYLOSIS)	**SACROILIAC JOINT INJECTION**
LUMBAR RADICULOPATHY (SCIATICA)	**TRIGEMINAL GANGLION BLOCK**
CERVICAL RADICULOPATHY	**SPHENOPALATINE GANGLION BLOCK**
EPIDURAL STEROID INJECTION (CIRCLE: CERVICAL, THORACIC, LUMBAR)	**SELECTIVE NERVE ROOT INJECTION @ ____ (INDICATE LEVEL)**
FACET JOINT INJECTION/MEDIAL BRANCH BLOCK	
TRANSFORAMINAL EPIDURAL INJECTION	

PLEASE NOTE: PATIENT MAY NEED DRIVER DAY OF AND ANTICOAGULATION/ANTIPLATELET TO BE HELD FOR NEURAXIAL PROCEDURES, REFER TO ASRA COAGULATION GUIDELINES APP FOR MORE DETAILS.

Please include all relevant imaging and investigations.