REFERRAL REQUEST FORM

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Please note FHO, FHN, or FHT access bonuses will not be affected by this referral*

IMPORTANT DETAILS	Referring Physician:
Patient Name:	Physician Fax #:
Date of Birth:	Physician Phone #:
Patient Phone #:	Physician Billing #:
Patient OHIP #:	Physician Address:

Purpose of this referral (please circle): **PAIN** or **ALLERGY TESTING** or **SPORT MEDICINE**
Case type (please circle, if applicable): **WSIB** or **MVA** → Is this case currently under litigation **YES** or **NO**

REASON FOR REFERRAL*:

- ☐ Spine Pain
- ☐ Post-Herpetic Neuralgia
- ☐ Trigeminal Neuralgia
- ☐ Headaches
- ☐ Diabetic Peripheral Neuropathy
- ☐ Fibromyalgia
- ☐ Carpal Tunnel Syndrome
- ☐ Temporomandibular Joint Disorder (TMJ)
- ☐ Joint, Bursa, or Tendon Pain
- ☐ Gout
- ☐ Trauma
- ☐ Sport or Overuse Injuries

Other (please specify):
_____
_____
_____

- ☐ Fibromyalgia/Chronic pain education program
- ☐ Diabetes education program
- ☐ Allergy (food, environmental, contact)

Symptoms:_____

***REFERRAL REQUIREMENTS:**

CONDITION	IMAGING	BLOOD WORK	ALTERNATIVE
Headaches	CT or MRI		Neurology consult report
Cervical, thoracic, or lumbar spine w/o radicular symptoms	X-Ray or none		
Cervical, thoracic, or lumbar spine with radicular symptoms	MRI or CT		
Shoulder or Elbow pain	MRI or Ultrasound		
Hip, knee, hand, wrist, foot, or ankle pain	X-Ray		
Abdomen or pelvis pain	Ultrasound or CT		GI/Gynecology consult report
Generalized pain		Required	Rheumatology consult report
Young patients (<50 yr)		Required	Rheumatology consult report

*****Please note, your referral will be returned if the above requirements are not met*****