Toronto Poly Clinic

Multi-Displinary Pain Management Center
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Pain Clinic Referral Form

Dear Doctor, Please use this form for your referrals

Patient Name: _____ Telephone : _____

Health Card : _____ VC : _____ DOB : _____

Address: _____

Referring Dr.: _____ Physician's #: _____

Address: _____

Telephone: _____ Fax: _____

1. Pain History: _____

_____

_____

2. Physical examination findings: _____

_____

_____

3. Investigations and Consultations: _____

_____

_____

Referred for (Check One)

- ☐ A-Pain Management
- ☐ B-Post MVA Rehabilitation
- ☐ C-Independent Assessment

WE CAN PROVIDE EARLY APPOINTMENTS TO YOUR CLIENTS