Kitchener Interventional Pain Clinic

www.kitchenerinterventionalpainclinic.ca

CHRONIC PAIN MANAGEMENT REFERRAL FORM

1585 Victoria St N
Kitchener, ON N2B 3E6
Tel:(519)340-5840
Fax: (519) 340-5850

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 PAIN SYNDROME AND SYMPTOMS NECESSITATING FLOUROSCOPY TREAMENT:

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.