MINERVA PAIN MANAGEMENT GROUP
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L8S-3C4

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Referral Form **Patients will be contacted directly in 1-2 weeks.

Patient Name:________________________________**OHIP # (with valid VC):**______________________________

Date of Birth:_________________________________ (Note: We only accept adult patients > 18years old)

Contact Phone #:____

Email address (if available):____

Home Address:____

____

Additional Insurances/Benefits (circle all that apply): MVA WSIB Extended Health Benefits

Pain Conditions (Circle all that apply)

Duration of Pain: Acute (<6wks) Subacute (6-12 wks) Chronic (>12 wks)

Pain Locations: **Head** **Face** **Neck** **Back:** Upper Middle Lower

Upper Limb: Shoulder Upper arm Elbow Forearm Wrist Hand/Fingers

Lower Limb: Hip Thigh Knee Lower Leg Ankle Foot

Relevant History/Investigations/Treatments:____

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***Please attach CPP, all recent imaging and laboratory investigations, prior consult notes, and prior/current medications (allergies)**

Consult Goals: 1) Assess/advise 2) Assess/Co-Manage as needed

REFERRING PHYSICIAN:____ **OHIP Billing #:**______________

Physician Office Phone:____________________________________**Office Fax:**____________________________

Family Physician (if not Referring):____
Is GP in a FHT/FHO/FHG/FHN (circle as warranted)