THE INTERVENTIONAL PAIN SPECIALISTS

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Interventional Pain Management Consultation Referral Form

Please complete this form and fax/email it. We will contact the patient directly.

Physician Info

CPSO#_____ Billing#_____
Name:[Last,First]_____
Address:_____City:_____PC:_____
Phone:_____ Email:_____
Fax:_____Website:_____Specialty:_____

Are you the patient's Fam. Physician? Yes / No.

Note: The referral must be supported by Physician's CPSO License and Billing Number

Providers:
☐ Check here if you want INFO about our facility and treatment options for your patients.
[please write your email]

Patient Info

Name:[Last, First]_____
DOB: MM / DD / YYYY _____ Preferred Phone: _____
Address:_____
City:_____PC:_____AlternatePhone:_____
Health Card Number:_____

** Bring a valid OHIP card and picture ID for consultation.• Visit *tipsmed.com* for more info. **

Patients:
• Include a valid Cell phone as primary contact.

CHIEF PAIN COMPLAINT

AGE, LOCATION, CHRONICITY, QUERY:

Signature:_____

Expedite service for:
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Large Joint

Direct Referral to:
☐Dr. J.C. Brown ☐Dr. F. Gonzalez M.

• If no preference, or expedite referral, please check here ☐

DON'T FORGET:

• INCLUDE IMAGING OR STUDY OF AFFECTED ANATOMY (X-RAY, MRI, ULTRASOUND, EMG, ETC.)

• PERTINENT PATIENT SUMMARY OR SPECIALIST REPORTS

OUR CENTER SPECIALIZES IN ADVANCED INTERVENTIONAL PROCEDURES FOR PAIN. TREATMENT IS FOR ADULTS 20+. SEE OUR WEBSITE FOR DETAILS

www.tipsmed.com