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New Patient

REFERRAL FORM

Full Name: _____ Date of Birth: DD MM YY

Phone Number: _____ Gender: ☐ Male ☐ Female ☐ Other

Email Address: _____ Family Dr Name: _____

Health Card Number _____ Address: _____

☐ Motor Vehicle Accident ☐ Work-Related Accident WCB claim No: _____

Chronic Pain Condition

Please select any of the following that apply to you

- ☐ Facial Pain
- ☐ Migraine headaches
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Muscle Pain
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Knee Pain
- ☐ Neuralgia
- ☐ Sciatica Nerve Pain
- ☐ SI Joint Pain
- ☐ Hip Pain
- ☐ Ankle Pain
- ☐ Fibromyalgia
- ☐ Other: _____

Medical History

Please select any of the following that apply to you

- ☐ Asthma
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Parkinsons'
- ☐ Depression/Anxiety
- ☐ COPD/Lung Disease
- ☐ Gastrointestinal Problems
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Endometriosis
- ☐ Liver disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Autoimmune Disease
- ☐ Pelvic pain
- ☐ Other: _____

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Medications

Please select any of the following that apply to you

- [ ] Amitriptyline
- [ ] Nortriptyline
- [ ] Gabapentin
- [ ] Oxycodone
- [ ] Duloxetine
- [ ] Cyclobenzaprine
- [ ] Ibuprofen
- [ ] Pregabalin
- [ ] Hydromorphone
- [ ] Venlafaxine
- [ ] Baclofen
- [ ] Acetaminophen
- [ ] Morphine
- [ ] Codeine
- [ ] Other: _____

Procedure History

Please select any of the following procedures you have had in the last 24 months

- [ ] HA injections
- [ ] Radiofrequency Ablations
- [ ] Cortisone Hip Injection
- [ ] Cortisone Small Joint Injection
- [ ] Spinal Surgery
- [ ] Hernia Repair Surgery
- [ ] PRP injections
- [ ] Epidural Steroid Injections
- [ ] Cortisone Knee Injection
- [ ] Cervical Spine Surgery
- [ ] Hip Surgery
- [ ] Abdominal Surgery
- [ ] Trigger Point Injections
- [ ] Lumbar Facet Injection
- [ ] Cortisone Shoulder Injection
- [ ] Shoulder Surgery
- [ ] Knee Surgery
- [ ] Other: _____

Treatment

Please select any of the treatments that you tried

- [ ] Chiropractor
- [ ] Physiotherapy
- [ ] Massage
- [ ] Acupuncture
- [ ] Osteopathy
- [ ] Naturopathy
- [ ] Other: _____

Patient Initials _____ Date DD MM YY

Once you complete your form, please send it to **Hello@genuvishealth.com** or fax it to **1-844-840-2474.**

If you have any questions or need assistance, please call +1 587-600-8158.
Our team will review your submission and follow up within 48 hours.