BOSS CLINIC

Brandon Orthopaedic & Spine Surgery Clinic

Pain Injection Referral Form

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: MM/DD/YYYY Phone: _____

PHIN: _____

Lumbar Spine

- ☐ Back Pain
- ☐ Leg Pain / Radiculopathy
- ☐ Neurogenic Claudication
- ☐ Spinal Stenosis / Disc Herniation

Shoulder

- ☐ Shoulder Osteoarthritis
- ☐ Rotator Cuff Tear / Tendinitis
- ☐ AC Joint Pain
- ☐ Frozen Shoulder

Knee

- ☐ Knee Osteoarthritis
- ☐ Meniscal Tear

Hip

- ☐ Hip Osteoarthritis
- ☐ Hip Bursitis

Imaging Completed: ☐ X-ray ☐ CT ☐ MRI ☐ Ultrasound

REFERRING PHYSICIAN

Name: _____ Billing #: _____

Signature: _____ Date: MM/DD/YYYY

Please Fax or Email this completed form.

Fax: (204) 515-0860

Email: refer@bossclinic.ca