REFERRAL FORM

THE OSHAWA

CHRONIC PAIN AND MIGRAINE CLINIC

Please Indicate if your clinic is affiliated with ☐ FHO ☐ FHT ☐ FFS

Date: _____

PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Address: _____

Home No: _____ Cell No: _____

OHIP No: _____

REFERRING PHYSICIAN

Dr: _____ Billing # _____

Tel No: _____ Fax No: _____

REASON FOR REFERRAL

☐ Chronic Neck Pain

☐ Chronic Lower Back Pain

☐ Chronic Migraines

☐ Whiplash Injuries

☐ Epidural

☐ Other:

☐ Arthritis of the Neck and Lower Back

☐ Cervical and Lumbar Radiculopathy

☐ Chronic Conditions Related to Arms and Legs

☐ Fibromyalgia

INTERVENTIONAL PAIN SPECIALIST

☐ **Dr. Khal Efala** MD, FRCSC

☐ **Dr. Ken Fern** MD, FRCSC

☐ **Dr. Gilbert Yee** MD, FRCSC

☐ **Dr. Fadi Hannouche** MD, FRCP

☐ First Available Physician

☐ **Dr. Osama Gharsaa** MBBCH, FRCSC

☐ **Dr. Ravdeep Kukreja** MD, CCFP

☐ **Dr. Hamilton Jeyeraj** MD, CCFP

PLEASE FAX REFERRALS TO 416-364-1166. PLEASE BE SURE TO INCLUDE ALL RELEVANT/RECENT IMAGING REPORTS.
IMAGING CD/PICTURES ARE PREFERRED BUT NOT REQUIRED
PLEASE NOTE IN ORDER TO BOOK PATIENT IN A TIMELY MANNER - ADDITIONAL INFORMATION MAY BE REQUIRED.
WE WILL CONTACT THE PATIENT DIRECTLY TO BOOK AN APPOINTMENT.

111 Simcoe St N, Oshawa, ON L1G 4S4
TEL: 289-316-1645 | FAX: 416-364-1166
thechronicpainandmigraineclinic.com