REFERRAL FORM

The Scarborough Chronic Pain and Migraine Clinic

Unit 105, 1939 Kennedy Road, Scarborough, ON M1P 2L9
Tel: (416) 412-0505 Fax: (416) 412-0101
Email: thescarboroughpainclinic@gmail.com

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

Date:

Patient Information

Patient's name:_____ Date of birth:_____
Address:_____
Cellphone No.: _____Home phone No.:_____
OHIP No.:_____

Referring Physician's Information

Doctor:_____Billing No.:_____
Telephone No.:_____Fax No.:_____

Reason for Referral

☐ Chronic neck pain
☐ Chronic back pain
☐ Epidural Steroid Injection
☐ Chronic migraines
☐ Chronic headaches

Chronic Pain Specialists

☐ Ken Fern MD, FRCSC
☐ Gilbert Yee MD, FRCSC
☐ Fadi Hannouche, MD
☐ First available pain specialist
☐ Pervez Ali MD, FRCSC
☐ Ravdeep Kukreja, MD

Required: Most recent imaging report for chronic neck and/or back pain referrals and list of medications.

Please fax completed referrals to (416) 412-0101. We will contact the patient directly to book an appointment.