Physio / Chiro / Osteo Referral Form

18 YEARS OF AGE OR OLDER

Health Care Provider Information:
(Name, Telephone, Fax number, Address, Email)

Patient Information:
(Name,Date of Birth, Health Card,Telephone & Address)

Primary complaint:

Treatment provided:

Mechanical concern addressed? Y N

Duration of pair compliant:

Is the patient on blood thinners? Y N

Has the patient tried BOTOX Y N

Patient's Family Doctor Name:

Address:

Phone Number: Fax Number:

Patient advised to make Family Doctor aware of referral to Ottawa Pain and Spine Institute. Consultation reports will be sent to both the referring provider and the family doctor.

Patient advised that referral to Ottawa Pain and Spine Institute is only for interventional treatment of their pain. If assessment of any other pain is required, a referral from the Family doctor will be required.

Provider: **Date:**

Provider Type: