

Fax/Email to Mississauga Pain Clinic

DATE: _____

FAX: 905-858-3527

EMAIL: jppainclinic@yahoo.ca

RE: _____

of Pages including the cover sheet: _____

Notes/Comments:

From Dr. _____

OHIP Billing #: _____

Confidentiality Note

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**Fast tract form for pain consult to
Mississauga Pain Clinic**

Suite 220, 6855 Meadowvale Town Centre Circle, Mississauga, ON L5N 2Y1
T: (905) 858-8512, F: (905) 858-3527, jppainclinic@yahoo.ca

DATE: _____ PHYSICIAN: _____

PATIENT INFO:
NAME: _____ PHONE: _____

ADDRESS: _____

DOB: _____ HEALTH CARD: _____

HT: _____ WT: _____

REASON FOR CONSULTATION: _____

PLEASE CHECK THE DIAGNOSIS

- ☐ Neck pain
- ☐ Cervical radicular pain
- ☐ Low back pain
- ☐ Lumbar radicular pain
- ☐ CRPS (RSD)
- ☐ Others:
- ☐ Unknown

PLEASE CHECK THE LOCATION OF PAIN

- | | | |
|-------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Low back | |
| <input type="checkbox"/> Arm | <input type="checkbox"/> Leg | <input type="checkbox"/> Other |

PLEASE CHECK THE INTEVENTIONAL PAIN PROCEDURES TO BE DONE

- ☐ Lumbar epidural steroid injection
- ☐ Cervical epidural steroid injection
- ☐ Fluoroscopic guided transforaminal epidural steroid injection
- ☐ Diagnostic lumbar medial branch block/facet block
- ☐ SI joint block
- ☐ Diagnostic cervical medial branch block/facet block
- ☐ Lumbar facet denervation with radiofrequency lesioning (neurotomy)
- ☐ Cervical facet denervation with radiofrequency lesioning (neurotomy)
- ☐ Stellate ganglion block
- ☐ Lumbar sympathetic block
- ☐ Other

Your faxed referral will not be processed unless you include:

- ☐ **Copies of MRI/CT/EMG**
- ☐ **Pain questionnaire filled out by your patient**
- ☐ **Previous pain assessment if any**

Specific questions that you want to ask: