(416) 901-2343
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NIKALI PAIN CLINIC

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COSMETIC MEDICINE | PAIN MANAGEMENT | REGENERATIVE MEDICINE | FUNCTIONAL MEDICINE

Please complete this form on our secure webpage at www.nikaliclinic.com/referral
OR
complete this form and fax or email to the following secure lines:
Fax: 416-628-6133 **Email: visit@nikaliclinic.com**

Referring MD Information:	Patient Contact Information:
Dr. Name: _____	Patient's Full Name: _____ DOB: _____
CPSO #: _____	Address: _____ OHIP #: _____
Billing #: _____	Phone #: _____ Email: _____

Reason for referral:

Primary Diagnosis: _____

PLEASE NOTE: Following information will be extremely helpful in accurate assessment

Patient's past tand current reatment profile:

Nerve Blocks or other Interventional treatments: ◯ No ◯ Yes - Detail if available:_____

Current Opioid Medications: ◯ **No** ◯ **Yes -** Name and Dose: _____

Surgery (What/When) _____

Multi-disciplinary Pain Program (When/Where) _____

Please attach copies of **MRI, CT rand any other imaging eports of the affected areas as well as copies of relevant consultations, treatments and surgical notes**

Does any of the followings applies to this patient:

MVA : ◯ **Yes** ◯ **No**

WSIB : ◯ **Yes** ◯ **No**

Ongoing Application for ODSP/ Ontario Work/Insurance Disability/ Other Disability programs: ◯ **Yes** ◯ **No**

Approved ODSP/ Ontario Work/Insurance Disability/ Other Disability programs: ◯ **Yes** ◯ **No**

Other Legal Disputes: ◯ **Yes** ◯ **No**

_____

Physician Signature