Soldiers' MEMORIAL HOSPITAL Orillia

OSMH Anesthesia Procedural Clinic Referral Form

Phone: 325-2201 ext. 3159 Fax: 705-325-5945

Patient Name:
Address:
City:
Referring Doctor:
Billing Number:

DOB:
Health Card Number:
Phone:
Date of referral:

Reason for referral:

☐ **Interventional Anaesthesia**

- ☐ Head
- ☐ Neck
- ☐ T-Spine
- ☐ L-Spine: ☐ Back dominant ☐ Leg dominant

Worse with: ☐ Flexion ☐ Extension

- ☐ SI Joint
- ☐ Other:

Imaging: ☐ CT ☐ MRI ☐ X-Rays ☐ US ☐ Other:

(Please attach reports)

Duration of Symptoms:

Previous Treatment:	**Successful**	**Unsuccessful**
Physiotherapy/Chiropractic	☐	☐
Bracing/Mobility Aids	☐	☐
Exercise Prescription/Weight Loss	☐	☐

Medications:

NSAID's/Tylenol	☐	☐
Opioid Analgesics	☐	☐
Neuromodulator	☐	☐

Current Medications: (please attach list) ☐ **Patient is taking Anticoagulants:**

Allergies:

PMHx:

Please attach relevant consults, reports and cumulative patient profile. WSIB referrals are not accepted. OWN patient referrals must contact contact physician directly. Medication will not be prescribed at this clinic.

Referring Physician Signature: