



Orillia MSK Interventional Procedure Clinic Referral Form

Phone: 325-2201 ext. 3159

Fax: 705-325-5945

Patient Name:

DOB:

Address:

Health Card Number:

City:

Phone:

Referring Doctor:

Date of referral:

Billing Number:

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: