REFERRAL FORM

Fax completed referral forms to 416-641-4520.
For questions call us at 416-413-7999 or
email us at info@afiyaclinictoronto.com

Patient Information

Name: _____ OHIP: _____

Date of Birth: _____ Phone: _____

Address: _____ Email: _____

Provider Information

Referring Provider: _____ Billing Number: _____

Fax/Email: _____ Phone: _____

Primary Care Provider: _____

Reason For Referral

Active WSIB Claim: ☐

Location of Pain: _____

Referral Pattern: _____

Duration of Pain: _____

Clinical Summary: _____

Type of Assessment

Urgent Assessment: ☐ Reason: _____

First Available Pain Physician: ☐

Specific Pain Physician: _____

Sports Medicine: ☐ Physiatry: ☐ Comprehensive Pain Consult: ☐ Specific Procedure: ☐

Interventional Pain Referral: ☐ Spasticity Management: ☐ Pain Psychiatry & Psychology: ☐

All referrals need to include the specific imaging as listed below:

Please attach the following:

All previous relevant imaging (MRI, CT, US, X-Ray) reports for patient within the last two years.

Baseline ECG if requesting infusion therapy.

AFIYA Spine & Pain Clinic
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