



## Specialist Consultation Referral

### PATIENT INFORMATION

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Birth Date (Y/M/D) \_\_\_\_\_ Gender \_\_\_\_\_  
 OHIP \_\_\_\_\_ Ver. Code \_\_\_\_\_  
 Email \_\_\_\_\_ Tel \_\_\_\_\_  
 Address \_\_\_\_\_

### PHYSICIAN INFORMATION

Physician Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_  
 Billing # \_\_\_\_\_ Date \_\_\_\_\_  
 Physician Signature \_\_\_\_\_

### REASON FOR CONSULTATION

#### Chronic Pain Syndrome

- ☐ Arthritis
- ☐ Inflammatory Polyarthropathy
- ☐ Post Operative/Traumatic
- ☐ Fibromyalgia
- ☐ Neuropathic \_\_\_\_\_
- ☐ Malignancy \_\_\_\_\_
- ☐ Other \_\_\_\_\_

#### Mental Health

- ☐ Anxiety/Depression
- ☐ PTSD
- ☐ Eating Disorder
- ☐ ADHD
- ☐ Other \_\_\_\_\_

#### Neurologic

- ☐ Cognitive Impairment
- ☐ Seizure Disorder
- ☐ Migraines/Headaches
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Other \_\_\_\_\_

#### Gastrointestinal

- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Other \_\_\_\_\_

#### Other

- ☐ Insomnia
- ☐ Sleep Disordered Breathing
- ☐ Appetite Stimulation
- ☐ HIV/AIDS
- ☐ Recreational User Consultation for Harm Prevention

#### Current Medications

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Currently taking Anticoagulants ☐ Yes ☐ No  
 Pregnancy or Family Planning ☐ Yes ☐ No  
 History of Substance Abuse/Addiction ☐ Yes ☐ No  
 History of Psychotic Illness ☐ Yes ☐ No

**RELEVANT MEDICAL HISTORY** – Please include Cumulative Patient Profile (CPP), all relevant test results and consultation notes.

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