ALLEVIO
PAIN MANAGEMENT

240 Duncan Mill Road, Suite 101
North York, Ontario M3B 3S6
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Fax form to:
(647) 427-4100

Referral for Dr. _____

◯ If waitlist is > 3 months, next doctor available

Date: _____ Patient's Name: _____ DOB: _____

Patient's OHIP #: _____ WSIB: _____ ◯ M ◯ F

Patient's phone #: (Home) _____ (Cell) _____ (Work) _____

Reason for referral – Please select all that apply and print clearly

◯ Back pain ◯ Neck pain ◯ Radiculopathy ◯ Headache ◯ Fibromyalgia ◯ CRPS/RSD

◯ Persistent Post-Surgical Pain ◯ MVA-related (Lawsuit) ◯ Other: _____

Specific intervention (for pre-approved providers only): _____

** Allevio physicians will not assume sole responsibility for prescription management, notably controlled substances. Please consider patient expectations prior to referral.

Allevio strives to minimize all wait times, but will prioritize those with potential to recover with aggressive management.

Condition is … ◯ Acute (onset < 3 months) ◯ Acute on Chronic ◯ Chronic (> 3 months, unlikely resolution)

◯ Complex (e.g. widespread pain, mood disorder) ◯ Cancer-related ◯ Palliative

Has the patient been to ER as a result of THIS pain in the past 6 months? ◯ No ◯ Yes, # times? _____

Is a return to work *realistic* with better pain control? ◯ Retired ◯ No ◯ Yes ◯ Still working

Allied services requested:
Allevio encourages patients to embrace the role of multimodal and multidisciplinary care for complex pain.

◯ Chiropractic ◯ Osteopathy ◯ Psychotherapy ◯ Acupuncture ◯ Bracing/Orthotics ◯ Training

Please provide us with all pertinent medical records including MRI, CT, X-ray, NCS/EMG, bone scan or lab (CBC, INR, PTT, Cr) reports, relevant consultations or prior treatment, current medical conditions and current medications and allergies.

Please note that the Allevio Pre-Consult Pain Questionnaire (www.allevioclinic.com/referrals) must be completed by the patient and returned before an appointment is set. Incomplete referrals may result in delayed consultation.

_____ _____ _____
Referring Physician's Name (print clearly) Referring Physician's Signature OHIP Provider #

Referring Physician's Direct Phone: _____ Fax: _____ Email: _____

If applicable, name of hospital and/or pre-approved unit: _____

*We will contact patients directly for appointments. All patients must have a family or referring physician who is willing to collaborate in patient care, including medication refills. Allevio has no impact on referring GP Access Bonus.