iScope
CONCUSSION & PAIN CLINICS

iScope Concussion & Pain Clinics - Chronic Pain

Virtual Clinic + Locations across Greater Toronto Area

www.myiscope.com

Toll-free: 1-888-550-5508

Send forms to intake@myiscope.com or fax 416-900-7006

Chronic Pain Referral Form

PATIENT INFORMATION:

NAME: _____ PHN: _____
Last First Middle

DATE OF BIRTH: _____ • client must be > 16 years of age Male ☐ Female ☐
dd/mm/yy

CURRENT ADDRESS: _____

PHONE NUMBER: _____ FAMILY DOCTOR: _____
Phone #

REASON FOR REFERRAL: _____

_____

HAVE YOU COMPLETED ANY PREVIOUS IMAGING? Y N (If yes, please attach copies of the report.)

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSES: _____

_____

_____

HAVE YOU COMPLETED ANY PREVIOUS TREATMENT OR INJECTIONS?

IF YES, PLEASE DESCRIBE THE TREATMENTS/INJECTIONS: _____

_____

_____

_____

REFERRING PROVIDER:

NAME/TITLE: _____
(Please print first and last name) Billing #

HOSPITAL & CONTACT INFORMATION: _____

HAS CLIENT BEEN INFORMED OF REFERRAL: Y N

SIGNATURE (Person completing form): _____ DATE: _____