PATIENT REFERRAL

Pain Management & Spine Care

"healing from within"

SHIELD CLINICS

Dr. Sherif El-Maadawy MB B Ch, MSc, FRCP(C), Master-CIME, Physiatrist
Dr. Brian Loewen MD, CCFP, Dip. Sport Med.
Dr. I. El-Gouhary MB B Ch, LMCC, CCFP, CIME
Dr. O. Vicaruddin MD, PgCPain, CIME

Patient Information

Patient Name:

Birth date (MM/DD/YYYY):

Address:

City:

Province: Postal Code:

Phone: Cell:

Email:

Gender: ☐ Male ☐ Female

PHN:

☐ Active WCB Claim Number:

Physician Information

Referring Physician:

PRACID:

Physician Address:

City:

Province: Postal Code:

Phone:

Email:

Fax:

Family Physician:

Referral Information

Reason for referral (provide any supporting documentation):

Previous history & investigations:

Medications:

Services Required

Indicate specific services required:

- ☐ Urgent Consultation
- ☐ Joint / Myofascial Injection
- ☐ Back pain (Acute or Chronic)
- ☐ Neck pain (Acute or Chronic)
- ☐ Spasticity Management
- ☐ Platelet-Rich Plasma
- ☐ Psychiatry
- ☐ General Phys. Med & Rehab Consult
- ☐ Pain Management
- ☐ Coordinate medications management with Chronic Pain Clinic

Fax this completed form to (780) 666 – 2621

For Internal Use Only: Initial Appointment Follow-Up Appointment

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