

CONSULTATION FORM**Dr. Abdallat | Interventional Chronic Pain | Great Lakes Clinic****FAX**
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Please complete this form and include all relevant supporting documentation (e.g., consultation notes, surgical reports, investigation results, and imaging reports) to help us assess and triage the referral. **Please fax and email the completed form and supporting documents.**

PATIENT INFORMATION

DATE	PATIENT NAME	DOB
GENDER	WEIGHT	OHIP CARD
OTHER INSURANCE	PHONE (HOME)	PHONE (CELL)

REASON FOR REFERRAL

- | | | |
|--|---|---|
| ☐ Back Pain | ☐ Neck Pain | ☐ Nerve Root compression |
| ☐ Cervicogenic Headache | ☐ Occipital Neuralgia | ☐ Spontaneous Intracranial Hypotension for EBP |
| ☐ SI Joint Pain | ☐ Knee Injection | ☐ Hip Injection |
| ☐ Shoulder Injection | ☐ Ankle Injection | ☐ Cancer Pain for Intervention |
| ☐ CTS | ☐ Neuropathy, specify: _____ | ☐ Other: _____ |

Pain duration: _____ ☐ Weeks ☐ Months ☐ Years**TREATMENTS ALREADY TRIED**

- | | | | |
|--------------------------------------|--|--|-------------------------------------|
| ☐ NSAIDs | ☐ Gabapentin | ☐ Pregabalin | ☐ Opioids |
| ☐ Nabilone | ☐ Amitriptyline | ☐ Nortriptyline | ☐ Duloxetine |
| ☐ Venlafaxine | ☐ Other: _____ | | |

POTENTIAL CONTRAINDICATIONS FOR THE INTERVENTION

- | | |
|--|--|
| ☐ Allergic reaction to local anesthetic or steroids | ☐ IV Drug Abuse |
| ☐ Active Infection | ☐ Poorly controlled Psychiatric condition |
| ☐ Patient is not interested in injection | ☐ Other: _____ |

REFERRING PROVIDER

REFERRING PROVIDER	OHIP BILLING #
SIGNATURE	PHONE
	FAX