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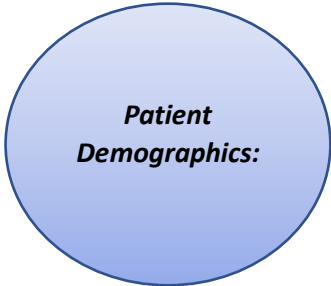
**PATIENT REFERRAL FORM**

**To expedite patient service, please include the following with the referral form:**

- 1- Complete list of current active medications
- 2- CPP
- 3- A copy of any relevant imaging (CT, MRI or Ultrasound) & any relevant physiological studies (NCS, EMG)

1- Please note that SWOPI will not assume the responsibility of opioid or other medication prescriptions. We believe in a team-based approach. Please consider patient expectations and goals before referral.  
 2- SWOPI will contact your patient directly with an appointment

Date (DD/MM/YYYY):     /     /



Patient Name:

First Name	Middle Name	Last Name
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Date of Birth (DD/MM/YYYY):     /     /     Patient Cell Phone #:

Patient email address:

Patient OHIP #:     Version Code:     WSIB #:

Patient Private Insurance (if any):     OWN #:



Patient's Family Doctor:     Family Doctor Fax Number:

Referring Physician (if not the patient's Family Physician):

Referring Physician Fax Number:

Referring Physician Billing #:     Referring Physician Signature:

**Reason for Referral** (please check all applicable):

<input type="radio"/> Low Back Pain	<input type="radio"/> Hip Pain    R    L
<input type="radio"/> Knee Pain    R    L	<input type="radio"/> Sciatica    R    L
<input type="radio"/> Shoulder Pain    R    L	<input type="radio"/> Neck Pain
<input type="radio"/> Chronic Headache	<input type="radio"/> Fibromyalgia
<input type="radio"/> CRPS	<input type="radio"/> Post-Surgical Pain

**Services:**

Epidural Steroid Injections

Facet Joint Neuro-Ablation

Knee & Hip Neuro-Ablation

Shoulder Joint Neuro-modulation

Lidocaine/ Ketamine Infusion

Lumbo-Sacral Nerve Root Neuro-Modulation