

THE JOINT PAIN CLINIC – REFERRAL FORM

OHIP-Covered

www.jointpaininstitute.ca • Appointments within 1–2 weeks • Dr. Mustafa Al-Waeli (Musculoskeletal Medicine)

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PATIENT INFORMATION

Patient Last Name, First Name	Date of Birth (DD/MM/YYYY)
Health Card # (OHIP) + Version Code	Phone #
Address (Street, City, Postal Code)	

CLINICAL DETAILS

Body Region (check all that apply): <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Foot Laterality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral
Reason for Referral: <input type="checkbox"/> Arthritis-related Pain <input type="checkbox"/> Day-to-day Aches/Pains <input type="checkbox"/> Sports/Recreational Injury <input type="checkbox"/> Other: _____
Onset/Mechanism (if injury): _____
Key Symptoms: _____ Pain Severity (0–10): 0 1 2 3 4 5 6 7 8 9 10 Duration: _____
Treatments Tried: <input type="checkbox"/> Rest/Activity Mod. <input type="checkbox"/> NSAIDs/Analgesics <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Bracing <input type="checkbox"/> Oral Steroids <input type="checkbox"/> Previous Injection (date/type): _____ <input type="checkbox"/> Other: _____
Relevant Medical History / Medications: _____ Anticoagulants/Antiplatelets: <input type="checkbox"/> None <input type="checkbox"/> ASA <input type="checkbox"/> Clopidogrel <input type="checkbox"/> DOAC <input type="checkbox"/> Warfarin (INR: __) Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No
Imaging Attached: <input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> MRI Dates: _____ Findings: _____
Suspected Diagnosis (if any): _____

REQUESTED SERVICE

- Assessment & Treatment Recommendation Viscosupplementation Injection Corticosteroid Injection
 Joint Aspiration / Fluid Drainage

Urgency: Routine (appointment within 1–2 weeks) Urgent (please specify): _____

REFERRING PROVIDER

Referring Provider (Name & Credentials)	CPSO / License #
Clinic / Address	Phone / Fax
	Preferred Contact Time
Signature	Date

Please fax this referral with recent imaging reports (if available). Patients will be contacted directly to schedule an appointment.

Thank you for your referral.