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New Patient Referral Form

Please complete this form and fax it to 416-512-6375 and we will contact the patient directly.

Physician Information FHN & FHO practitioners circle here to avoid OHIP billing issues: FHN/FHO

First Name	_____	Last Name	_____
Address	_____	Phone Number	_____
Unit Number	_____	Fax Number	_____
City	_____	Physician Number	_____
Province	_____	Today's Date	_____
Postal Code	_____	Physician Signature	_____

Circle The Referral Type

HEAD NECK BACK FACIAL OTHER OHIP WSIB BOTOX MVA DATE:

Patient Information

First Name	_____	Last Name	_____
Address	_____	Home Phone	_____
Unit Number	_____	Work Phone	_____
City	_____	Cell Phone	_____
Province	_____	Health Card #	_____
Postal Code	_____	Date Of Birth	_____

Please Fax The Following Information With This Referral Form

Location, cause, and date of onset of pain.

Relevant reports from x-rays, CT scans, MRI, EMG, bone scans, blood work, and specialists.

A list of the patient's current and previous medications.

A summary of the patient's current health conditions.