CPRI Canadian Pain & Regenerative Institute

Patient Name:
DOB:
MSP #:
(*may attach label here*)

Physician consultations, follow up appointments, and the majority of physician services are covered by MSP. All patients require referral from a physician with an MSP Billing number.

Date: _____

Dear Medical Doctor:

Your patient is currently receiving treatment at _____

Practitioner:_____ Program/Service_____

Problem/ Injury: 1. _____

2. _____

In order to optimize care and treatment, a referral to a CPRI Physician has been requested for the following reason(s):

- ○ Rehabilitation/recovery not progressing or is progressing slowly
- ○ Consideration of procedural pain management (e.g. ultrasound/ fluoroscopy-guided spinal and peripheral injections) offered at CPRI
- ○ Additional evaluation/ imaging may be warranted

Practitioner comments:

_____

_____

_____

Physician to complete:

____ I would like to refer this patient to a CPRI Physician.

____ I do not want to refer this patient to a CPRI Physician.

____ I would like additional information about treatments and services at CPRI.

MD Name:_____ MSP #:_____ Fax #:_____

MD Signature:_____

Please fax (604-325-8577) or e-mail (admin@cprihealth.ca) this form for processing.