FRASER VALLEY
PAIN MANAGEMENT CLINIC

Pain Specialist/Anesthesiologist

Dr. Michael Breden

(Please Print Clearly)

Date(M/D/Y):_____ **Referring Doctor name & MSP#**_____

Referring Office Information:

Address: _____ **Phone:** _____

Fax: _____

Patient Information:

Name:_____ DOB(M/D/Y):_____ _

PHN #_____ Address:_____

Home Phone:_____ Email:_____

Alternate Phone:_____

Reason For Referral:_____

_____

Diagnosis: _____

Please note there may be fees for certain procedures.

History & Examination:_____

_____

Is the pt on Blood thinners?_____

name and dosage

Please have pt stop blood thinners 7 days prior to injection/in-person appointment.

*****If pt is on Warfarin they must have an INR done the day before their appointment. *****

Is the pt Diabetic?_____

Has pt had a CT scan or MRI done in last year?_____ Date_____ Attached_____

Must include copy of patient's CT, MRI, or X-Ray with submission.