

THE SHAPERO MARKHAM HEADACHE AND PAIN TREATMENT CENTRE

www.shaperoheadache.com

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■ Board Certified Pain Practitioner

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DATE _____

REQUISITION FOR CONSULTATION

PATIENT NAME: _____

DATE OF BIRTH: _____ TEL# () _____

PATIENT ADDRESS: _____

- HEADACHE DIAGNOSIS MANAGEMENT
- BOTOX THERAPY
- THERAPEUTIC NERVE BLOCKS / TRIGGER POINT INJECTION
- DIAGNOSTIC FACET NERVE BLOCKS

DIAGNOSTIC FACET NERVE BLOCKS REQUESTED:

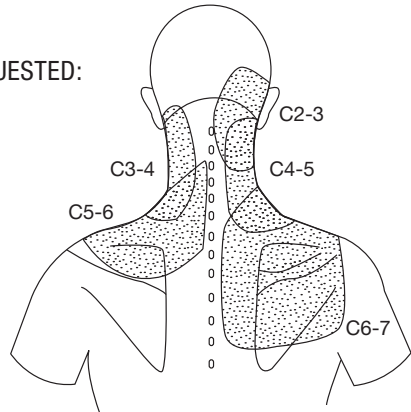
C2/C3 _____ L2/3 _____

C3/C4 _____ L3/4 _____

C4/C5 _____ L4/5 _____

C5/C6 _____ L5/S1 _____

C6/C7 _____



REFERRING PHYSICIAN (Print) _____

TEL# () _____ FAX# () _____

For appointments please fax requisition and/or call the Shapero Headache And Pain Treatment Centre.

All patients will be referred back to their referring physician/pain clinic for continuing medical and pain management care.