Musculoskeletal Program – Spine

This form is <u>not</u> to be used for urgent referrals.

Request For Consultation
Fax: 613-721-7889

Incomplete Referrals Will Be Returned

REFERRAL DATE (YYYY/MM/DD):

REASON FOR REFERRAL:

Language Requirement: ☐ English ☐ Bilingual ☐ French Only ☐ Arabic Only

Referring Physician Information – may use stamp

Name:
_____
Specialty:
_____
Address:
_____
_____
Phone:
_____
Fax:
_____
Billing #:
_____
Signature:
_____

Family Physician Information (if different)
Name:
_____
Phone:
_____
Fax:
_____

Patient Information – may use sticker

Name:
_____
Address:
_____
_____
_____
Phone:
_____
Date of Birth:
_____
Health Card #:
_____
Gender:
☐ Male ☐ Female

Alternate Contact Information:
_____
_____
_____

Spinal Level:

☐ Cervical
☐ Thoracic
☐ Lumbar-Sacral

Pain Dominance:

(for severity of pain, use 0-10 scale, 10 = worst imaginable)

☐ Back, Severity: _____
☐ Neck, Severity: _____
☐ Leg ☐ Left ☐ Right ☐ Bilateral
Severity of Leg Pain: _____
☐ Arm ☐ Left ☐ Right ☐ Bilateral
Severity of Arm Pain: _____

Specify Dermatome: _____

Duration of Symptoms:

☐ <6 Weeks
☐ 6-12 Weeks
☐ 3-6 Months
☐ 6-12 Months
☐ >12 Months

Objective Neurological Loss (select all that apply) (Must Provide Details):

☐ Motor: _____
☐ Sensory: _____
☐ Gait / Balance: _____
☐ Bowel: _____
☐ Bladder: _____
☐ Upper Motor Neuron Signs: _____
☐ Other: _____

Is patient's pain / disability significant enough that they would like to undergo surgery?

☐ Yes
☐ No
☐ Maybe

Diagnosis:

☐ Back Pain
☐ Neck Pain
☐ Radiculopathy / Sciatica
☐ Myelopathy
☐ Neurogenic Claudication
☐ Deformity / Scoliosis / Kyphosis
☐ Other
Specify: _____

Pathology:

☐ Disc Herniation
☐ Degenerative Disc Disease /Facet Arthropathy
☐ Spinal Stenosis
☐ Spondylolisthesis
☐ Deformity / Scoliosis / Kyphosis
☐ Fracture – Traumatic
☐ Fracture – Pathological
☐ Tumour
☐ Intradural
☐ Inflammation
☐ Infection
☐ Other
Specify: _____

Treatment to Date:

☐ None
☐ Physiotherapy
Length of Time: _____
Benefits Received: _____
_____
☐ Cortisone Injection(s)
Response to Injection: ☐ None
☐ Partial
☐ Complete
☐ Exercise Program(s)
Length of Time: _____
Benefits Received: _____
_____
☐ Other
Specify: _____

Surgeon Preference:

☐ First Available Surgeon
☐ Specific Surgeon:
_____

Diagnostic Imaging:

Attach minimum 1 MRI Report (within the last 1 year)

☐ MRI report has been attached

If unable to get MRI due to medical contraindication, please specify reason: _____
_____

If unable to get MRI, please attach one of the following reports:

☐ CT ☐ CT myelogram

Please attach any relevant consultation reports from other specialists.