**Musculoskeletal Program – Spine**

**\*This referral is not to be used for urgent referrals.\*** Cornwall Community Hospital - Hôpital Montfort- Queensway Carleton Hospital

The Ottawa Hospital - Pembroke Regional Hospital

**Request For Consultation**

**Fax: 613-721-7889**

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| **REFERRAL DATE (YYYY/MM/DD):** |
| **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 [ ]  FemaleAlternate Contact Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Spinal Level:**[ ]  Cervical [ ]  Thoracic [ ]  Lumbar-Sacral**Pain Dominance:**(for severity of pain, use 0-10 scale, 10 = worst imaginable) [ ]  Back/Neck Severity of Back Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Severity of Neck Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  LegSeverity of Leg Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  ArmSeverity of Arm Pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specify Dermatome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Specify Laterality: [ ]  Left [ ]  Right [ ]  Bilateral**Duration of Symptoms:**[ ]  <6 Weeks[ ]  6-12 Weeks[ ]  3-6 Months[ ]  6-12 Months[ ]  >12 Months**Objective Neurological Loss (select all that apply):**[ ]  Motor[ ]  Sensory[ ]  Bowel/Bladder[ ]  Upper Motor Neuron Signs[ ]  Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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 attachedIf unable to get MRI, please specify reason: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If unable to get MRI, please attach one of the following reports:[ ]  CT [ ]  CT myelogram  |