Thunder Bay Regional Health Sciences Centre

Riverside Health Care

DRHC Dryden Regional Health Centre

Lake of the Woods District Hospital

RAPID ACCESS CLINIC

SPINE PROGRAM REFERRAL

PATIENT INFORMATION/LABEL

Health Card Number: _____

Last Name: _____

First Name: _____

Gender: ☐ Male ☐ Female

Date of Birth: _____ Age: _____

Address: _____

Preferred Contact Number: _____

Email: _____

Guidelines:
1. Referring Physician to complete referral form.
2. Referral is to be faxed to the Rapid Access Clinic at 1-844-497-2445
3. The Rapid Access Clinic clerk will receive the referral form and route to the appropriate health care provider.
4. Completed referrals will be filed in the Rapid Access Clinic on the patient's health record.

If patient presents with any of these symptoms, please send patient to the Emergency Department

- **Recent onset bowel/bladder dysfunction/incontinence/cauda equina**
- Recent history of severe trauma – i.e. motor vehicle accident, fall
- Progressive paraparesis/quadraparesis/neurology

Urgent Referral Criteria: http://www.criticall.org/getattachment/Help-My-Patient/Consultation-Guidelines/Revised-Neurosurgery-Consultation-Referral-Guidelines_FINAL_English_March2018.pdf.aspx?lang=en-US

REASON FOR REFERRAL

Primary Complaint/Clinical Concern: _____

_____

Examination Findings: _____

_____

PRESENTING SIGNS & SYMPTOMS (select all that apply)

Cervical Spine ☐ **Thoracic Spine** ☐ **Lumbar Spine** ☐

Upper Extremity ☐ Right ☐ Left ☐ Bilateral **Lower Extremity** ☐ Right ☐ Left ☐ Bilateral

Weakness ☐ Stable ☐ Worsening
Numbness/Tingling ☐ Stable ☐ Worsening
Pain ☐ Stable ☐ Worsening
Other (specific)_____

Duration:
☐ Less than 6 weeks
☐ Between 6-12 weeks
☐ More than 12 weeks (please specify) _____
_____

Has there been previous surgery for back or neck problems? ☐ Yes ☐ No
Describe: _____

_____

Is this a 2nd Opinion? Explain: _____

☐ First available surgeon ☐ Preferred Surgeon _____ ☐ Preferred Site_____

Weight _____ BMI _____ Patients with BMI >40 or weight >300lbs are ineligible for elective spine surgery

INVESTIGATIONS: Any imaging not found on TBRHSC PACS must be forwarded with films (not reports)

☐ X-ray ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ EMG

REFERRING PHYSICIAN: **Name:** _____ **Date:** _____

(stamp or complete) **MSP #:** _____ **Specialty:** _____

Telephone: _____ **Fax:** _____

DRAFT