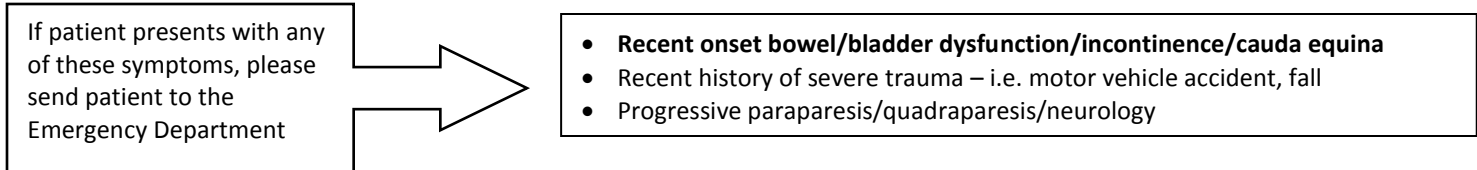




RAPID ACCESS CLINIC
SPINE PROGRAM REFERRAL

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.



Urgent Referral Criteria: http://www.critical.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
 Duration: Less than 6 weeks
Numbness/Tingling Stable Worsening
 Between 6-12 weeks
Pain Stable Worsening
 More than 12 weeks (please specify) _____
Other (specific) _____

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:** _____

