

Patient Information		
*Name:		OHIP#: _____ VC#: _____
Female Male	Age: *Date of Birth: mm/dd/yyyy	*Daytime Phone#: ()
*Address:		*City: _____ *Postal Code: _____
Patient is eligible for Rapid Access Clinic - Low Back Pain (RAC - LBP) referral if over 18 years of age with: Persistent LBP and/or related symptoms (e.g., sciatica, neurogenic claudication) that is not improving 6 wks. to 12 mos. from onset OR Unmanageable recurrent episodic LBP and/or related symptoms of <12 mos. duration post-recurrence.		
IMPORTANT: Patient is ineligible for RAC - LBP referral if one or more of the conditions apply:		
<ul style="list-style-type: none"> ▪ Patient with RED FLAGS ▪ Initial low back related symptoms <6 weeks post onset ▪ Constant/persistent LBP-related symptoms >12 months post onset ▪ <18 years of age ▪ Unmanaged established chronic multisite pain disorder ▪ Unmanaged established narcotic dependency ▪ Active LBP-related WSIB claim ▪ Active LBP-related motor vehicle accident claim ▪ Active LBP-related legal claim ▪ Pregnant/post-partum patients (<1 year) 		
Reason for referral: (check all that apply)		
<input type="checkbox"/> Clarify diagnosis <input type="checkbox"/> Recommend further treatment <input type="checkbox"/> Recommend appropriate imaging <input type="checkbox"/> Clarify activity limitations / restrictions <input type="checkbox"/> Clarify need for specialist referral <input type="checkbox"/> Other, please specify: _____		
Back Specific History		
1. Where has the pain / symptoms been the worst? (Check one) <input type="checkbox"/> Back Dominant <input type="checkbox"/> Leg Dominant	3. *Is there a previous history of back problems? <input type="checkbox"/> No Yes. Describe: _____ _____	
2. *Are emergent RED FLAGS present? <ul style="list-style-type: none"> ▪ Possible Cauda Equina Syndrome: <ul style="list-style-type: none"> ▪ Loss of anal sphincter tone/ fecal incontinence ▪ Saddle anaesthesia about anus, perineum, or genitals ▪ Urinary retention with overflow incontinence ▪ Progressive neurologic deficit ▪ Significant trauma No Yes. Please refer patient <u>directly</u> to the closest Emergency.	4. *Previous investigations, treatment or surgery for back problems? No Yes. Describe: _____ _____	
5. Relevant co-morbidities / Comments: _____ _____		
Does the patient have any YELLOW FLAGS? <input type="checkbox"/> Belief that pain is harmful or severely disabling <input type="checkbox"/> Fear avoidance behaviour (avoiding activity because of fear of pain) <input type="checkbox"/> Low mood and social withdrawal <input type="checkbox"/> Expectation that passive treatment rather than active treatment will help		
Does the patient speak: English French <input type="checkbox"/> Neither. If patient does not speak either English or French, we recommend they bring a translator.		
I hereby refer the above noted patient to RAC - LBP and a physician specialist as appropriate.		
*Referring Practitioner Name:		*Billing#: _____ *CPSO#/CNO#: _____
*Practitioner Address:		*Fax#: ()
Practitioner Signature:		*Date of Referral: mm/dd/yyyy