Sunnybrook Integrated Spine Referral Form

Referral Date: YYYY | MM | DD

FAX TO: 416-599-4577

CONSULTATION REQUESTED FROM: (select one)
Note: if no selection is made, referral will be processed as "next available".
☐ **Next available Integrated Spine surgeon OR specifically:** ☐ **Dr.** ____________________

Physician Information

Referring Physician Information

Name: ____________________
Specialty: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________
Email: ____________________
Billing #: ____________________
Signature: ____________________

Family Physician Information (if different)

Name: ____________________
Phone: ____________________

Patient Information

Name: ____________________
Address: ____________________
____
Date of Birth: ____________________
Health Card #: ____________ VC: ____________
Gender: ☐ Male ☐ Female ☐ ____________
Language if unable to speak English: ____________
Phone (Home): ____________________
Phone (Work): ____________________
Phone (Cell): ____________________
Email: ____________________
WSIB* #: ____________________
*If this is an active WSIB case, please refer though the WSIB specialty program

Referral Area:
☐ Spine
- ☐ Occipital-cervical, cervical, or cervicothoracic junction
- ☐ Thoracic
- ☐ Thoracolumbar junction
- ☐ Lumbar or lumbosacral
- ☐ Spinopelvic, sacral/coccygeal

Diagnosis/Primary Reason For Referral:
☐ Disc herniation
☐ Arthritis/degenerative disk disease
☐ Stenosis/spondylolisthesis
☐ Spinal cord compression (myelopathy)
☐ Radiculopathy (arm or leg sciatica)
☐ Degenerative scoliosis
☐ Opinion on prior surgery
☐ Other: ____________________

URGENCY: ☐ Routine ☐ Urgent

Clinical Information

PLEASE ATTACH RELEVANT IMAGING, OPERATIVE REPORTS AND REPORTS OF OTHER RELEVANT INVESTIGATIONS

CURRENT SYMPTOMS (select all that apply):
☐ Low back dominant pain*
*Patients with Low Back Dominant pain should be referred to a Low Back Rapid Access Clinic. For referral information, visit **lowbackrac.ca**
☐ Leg dominant pain: ☐ Left (specify location): ____________
☐ Right (specify location): ____________
☐ Neck pain
☐ Arm dominant pain ☐ Left (specify location): ____________
☐ Right (specify location): ____________
☐ Thoracic pain
☐ Extremity paresthesia (specify): ____________
☐ Extremity weakness (specify): ____________
☐ Deformity: ____________
Other: ____________

TREATMENTS TO DATE
Select all that apply:
☐ Analgesics
☐ Non-steroidal anti-inflammatory drugs
☐ Injections
- ☐ Steroid
- ☐ Other: ____________

☐ Physiotherapy and/or occupational therapy
☐ Previous surgery (please describe):
____
☐ Other: ____________

For bowel and/or bladder symptoms consistent with or suggestive of cauda equina compression, please direct patient to Emergency Department

CURRENT MEDICATIONS

RELEVANT PAST MEDICAL HISTORY

Has there been a recent significant change in physical or neurologic function, pain level and/or range of motion?
Are there systemic signs (e.g. fever, chills)? Other significant Issues?

PLEASE FORWARD ANY ADDITIONAL INFORMATION THAT WILL ASSIST US IN DETERMINING URGENCY