If patient presents with any of these symptoms, please contact spine surgeon on-call through VGH switchboard

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

REASON FOR REFERRAL
Primary Complaint/Clinical Concern:

Examination Findings:

PRESENTING SIGNS & SYMPTOMS (please indicate on diagram)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Stable</th>
<th>Worsening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Numbness/Tingling</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pain</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other (specific) ____________________________

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

Is there a previous history of back or neck problems? ☐ Yes ☐ No
Describe: ____________________________

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

Is this a 2nd Opinion? Explain: ____________________________

What is the overall level of disability? ☐ No limitations
☐ Mild limitations – able to do most activities with minor modifications
☐ Moderate limitations – able to do most activities with modifications
☐ Severe Limitations – unable to perform most activities

INVESTIGATIONS (Please indicate investigations done and forward results/films with referral)
☐ X-ray ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ EMG ☐ Other: ____________________________

REFERRING PHYSICIAN
Name: ____________________________
MSP #: ____________________________
Stamp or Complete
Telephone: ____________________________
Date: ____________________________
Specialty: ____________________________
Fax: ____________________________