Request for Spine Consultation

Fax: 905.577.8008

Telephone: 905.527.4322 ext. 46781

Patient Name: ______________________________

Dr. Aleksa Cenic, Neurosurgeon

Spine Clinic, McMaster Clinic Wing

Hamilton General Hospital, 7th Floor, Room 715

237 Barton St. E., Hamilton, ON L8L 2X

Referral for: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Second Opinion

Duration: ☐ less than six weeks ☐ between 6-12 weeks ☐ more than 12 weeks (please specify) ____________

Severity: ☐ interferes with work ☐ interferes with home life ☐ interferes with sports/leisure activities

PRESENTING SIGNS & SYMPTOMS (Please check all that apply and indicate/draw on the diagrams below. Be specific.)

Weakness R L
- ☐ improving
- ☐ stable
- ☐ worsening
- ☐ Spasticity

Numbess/tingling R L
- ☐ improving
- ☐ stable
- ☐ worsening

Pain Front R L Back L R
- ☐ improving
- ☐ stable
- ☐ worsening

RED FLAGS ☐ none

- ☐ bowel/bladder discharge (sudden sphincter dysfunction)
- ☐ severe trauma
- ☐ progressive parapesis/quadraparesis/neurology

▶ If patient presents any of the above, please send to nearest emergency room.

- ☐ unexplained weight loss, fever, chills
- ☐ saddle anethesia without bowel/bladder discharge
- ☐ acute pain not eased by recumbent position
- ☐ incremental non-relenting pain

▶ If any of these are present, please page Spine on-call at Hamilton Health Sciences.

INVESTIGATIONS *Please indicate investigations done and forward results with referral.**

☐ X-Ray ☐ CT ☐ MRI ☐ Bone Scan ☐ EMG Other: ____________

TREATMENTS TO DATE

☐ NSAIDs ______ months ☐ physiotherapy times ________

☐ opioids ______ months ☐ injections specify ________

☐ neuropathic ______ months ☐ pain clinic times ________ Other: ____________

PMHx (please check all that apply)

☐ spine deformity/scoliosis ☐ previous spine surgery ☐ cancer ☐ inflammatory arthritis ☐ osteoporosis

COMMENTS ______________________________

____

REFERRING PHYSICIAN

STAMP or COMPLETE

Name ____________ Fax ____________

License# ____________ Email ____________

Specialty ____________ Signature ____________

Telephone ____________ Date ____________

* Please note that all medical records/history must be faxed/mailed prior to scheduled appointment. All films must be couriered or brought by patient for scheduled appointment. Hamilton Health Services or St. Joseph's are on PACs.

Please inform your patient that if these are not available, the appointment will be rescheduled.