Shared health Soins communs Manitoba

Manitoba Spine Clinic

Spine Referral Form

Phone: **204-787-7500** Fax: **204-787-7631**
https://sharedhealthmb.ca/services/manitoba-spine-clinic

MRN: Visit #

Last Name, First Name:

Date of Birth (dd/mmm/yyyy)

Sex: □ Female □ Male

PHIN:

MB Reg #:

Referral Date D D M M M Y Y Y Y

Please choose preferred referral recipient

☐ **Manitoba Spine Assessment Clinic** ☐ **Next Available Surgeon** ☐ **Surgeon Requested:** _____

To ensure prompt and appropriate referral of your patient, please complete this form and send to Manitoba Spine Clinic referral fax #204-787-7631
We will use this data to ensure appropriate patient prioritization.

Patient Contact Information

Name		**Home**
Address		**Mobile**
City	**Province**	**Postal Code**

Referring Clinician

Name/Clinic		**Phone**
Address		**Fax**

Referral Type

☐ **New** ☐ **Repeat** ☐ **WCB** ☐ **WCB Appeal** ☐ **MPI** ☐ **2nd Opinion**

Referral Reason

Body Area Affected		
☐ **Cervical**	☐ **Thoracic**	☐ **Lumbar**
☐ Numbness or tingling	☐ Numbness or tingling	☐ Numbness or tingling
☐ Weakness - if present, is it: ☐ Acute ☐ Chronic ☐ Sudden onset ☐ Progressive	☐ Weakness - if present, is it: ☐ Acute ☐ Chronic ☐ Sudden onset ☐ Progressive	☐ Weakness - if present, is it: ☐ Acute ☐ Chronic ☐ Sudden onset ☐ Progressive
☐ Clumsy hands or feet	☐ Clumsy hands or feet	☐ Clumsy hands or feet
☐ Distal Pain Radiation ☐ Upper Quadrant ☐ Unilateral ☐ Lower Quadrant ☐ Bilateral	☐ Distal Pain Radiation ☐ Upper Quadrant ☐ Unilateral ☐ Lower Quadrant ☐ Bilateral	☐ Distal Pain Radiation ☐ Upper Quadrant ☐ Unilateral ☐ Lower Quadrant ☐ Bilateral
Additional comments	Additional comments	Additional comments

☐ **Scoliosis:** ☐ Degenerative ☐ Congenital ☐ Impaired Respiratory Status ☐ Pulmonary Function Test (PFT) Enclosed

☐ Adult Degree: _____

☐ Pediatric Degree: _____

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Spine Radiology

The following radiology reports are attached:		
	D D M M M Y Y Y Y	
☐ X-Ray	Date:	Location:
☐ CT Scan	Date:	Location:
☐ MRI	Date:	Location:
☐ CT / Myelogram	Date:	Location:
☐ Bone Scan	Date:	Location:

Spine Pathology

Pathology:	☐ Disc Herniation	☐ Degenerative Disc Disease / Facet Arthropathy	☐ Spinal Stenosis	☐ Spondylolisthesis
	☐ Deformity / Scoliosis / Kyphosis	☐ Fracture - Traumatic	☐ Fracture - Pathological	☐ Tumour
	☐ Intradural	☐ Inflammation	☐ Infection	
	☐ History of Malignancy - Diagnosis: _____			
	☐ Other: *(specify)*			

Symptom Duration

☐ less than 2 weeks ☐ 2–6 weeks ☐ 6–12 weeks ☐ 3–6 months
☐ 6–12 months ☐ 12–24 months ☐ more than 24 months

☐ Inability to work because of pain
☐ Pain which awakens patient from sleep
☐ Overuse of medication/substances for pain

☐ Degenerative ☐ Congenital ☐ Chronic ☐ Traumatic
☐ Altered bowel/bladder function
☐ Digital Rectal Exam Completed: ☐ Yes ☐ No
Specify: _____

Previous Management

☐ None ☐ Physiotherapy ☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Pain Clinic ☐ Physical Medicine
☐ Previous spine surgery? – Please include a copy of OR report
☐ Manitoba Spine Assessment Clinic
☐ Other: _____
☐ Recommended for surgery by another surgeon - if yes, by whom? _____

Additional Information

_____
_____
_____
_____
_____
_____

Referring Practitioner Confirmation:

I hereby refer the above noted patient to Manitoba Spine Program as appropriate.

_____ PRINTED NAME AND DESIGNATION

_____ SIGNATURE

Date: D D M M M Y Y Y Y

Legend
MPI - Manitoba Public Insurance OR - Operating Room WCB - Workers Compensation Board of Manitoba