Concord Repatriation General Hospital – Neurosurgery Clinic

SPINAL REFERRAL FORM

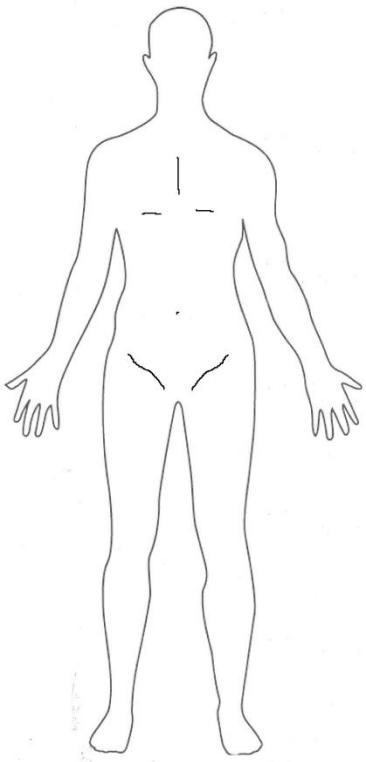
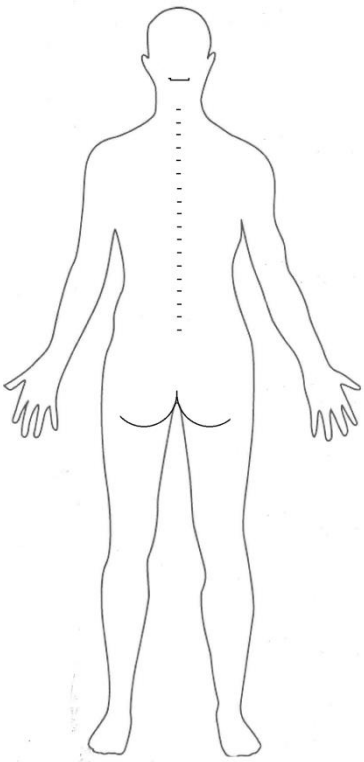
Patient Details

Last Name:		First name:	
Phone Number:		Address:	
Medicare No:		DOB:	

Referring Physician

Name:		First name:	
Practice Address:			
Phone:		Fax:	

Please indicate the area of symptoms

Front	Back	Tick if appropriate	
		**Clinical findings**	
		Fine motor skills dysfunction?	
		Bowel / bladder dysfunction?	
		Babinski / clonus / Hoffmans?	
		Immobility requiring aids? (wheelchair / walking frame)	
		Focal / myotomal weakness	
		Spasticity?	
		Saddle anaesthesia?	
		Known malignancy?	
		Fevers / rigors?	
		Unexplained weight loss?	

Radiological Findings	**CT**	**MRI**
Moderate canal stenosis		
Severe canal stenosis		
Foraminal narrowing		
Root compression		
Spondylolisthesis		
Instability		
Deformity		
Spinal cord compression		
Cord signal change/syrinx		

Symptom duration	<6 weeks	6-12 weeks	3 -9 months	9-18 months	>18 months

Treatments	**Response**			
Physical therapy	Not tried	None	Short	Sustained
CT guided steroid injections	Not tried	None	Short	Sustained

For urgent referrals please contact the emergency department or an on-call neurosurgery service via Concord switch board ph: (02) 9767 5000 fax: (02) 9767 7807.