THE SPINE CENTRE

SURGICAL REFERRAL

1st Floor, Westminster Tower, Zone E, LHSC
800 Commissioners Rd. E., London, On. N6A 5W9
Tel: (519) 685-8055 Fax: (519) 685-8059

***Please complete fully to ensure immediate processing* (do not fax more than once)**

DATE SENT: DATE REC'D:

PATIENT INFORMATION

Patient Name:	Home #:
Address:	Work #:
	OHIP #:
D.O.B:. Age: Height: Weight:	

REFERRING PHYSICIAN

Name & Referring Physican #:	Office #:
Address:	**Fax #:**

Is this patient interested in Surgery?	**Yes**	**No**
Do you feel that this patient is need of URGENT surgical attention	**Yes**	**No**
Reason:		

PATIENT PROBLEM

Location:	Cervical	Thoracic	Thoracolumbar	Lumbar

Diagnosis:	**Please check**		**Date of Onset**
Cervical / Thoracic myelopathy	Yes	No	
Radiculopathy	Yes	No	
Neurogenic claudication	Yes	No	
Spondylolisthesis	Yes	No	
Inflammatory Disease	Yes	No	
Fractured spine	Yes	No	
Tumour	Yes	No	
Infection	Yes	No	
Mechanical pain	Yes	No	

DEFORMITY

Scoliosis:	Kyphosis:

TREATMENT / TEST (attach results) ***FILMS/DISC TO ACCOMPANY PATIENT***

	Date	Where		Date	Where
X-ray			MRI		
CT scan			Myelogram		

Previous Surgery:

For Office Use Only	
Urgent	
Surgical	
Consulation	
Can't Help	

SURGICAL

Kevin R. Gurr, MD, FRCSC WSIB YES NO
Chris S. Bailey, MD, FRCSC
Fawaz Siddiqi, MD, FRCSC
Parham Rasoulinejad, MD, FRCSC

PLEASE COPY AND USE FOR FUTURE REFERRALS