



FMC Patient UR Number (if available): Date: / /

Personal Details

Mr Mrs Miss Ms Dr Prof Other:

Last Name:

Given Names:

Previous Surnames:

Address:

Phone (home): Phone (work): Mobile:

DOB: / / Gender Identity: Male Female Other Identifies as Aboriginal / Torres Strait Islander:

Interpreter required: Yes No Language:

General Practitioner Details

Name:

Clinic:

Address:

Phone: Fax:

Email:

Signature:

Clinical Information

Spinal Area: Cervical Thoracic Lumbar

Symptom duration: 0-6 weeks 6-12 weeks 3-9 months 9-18 months >18 months

Clinical Assessment:	Pathology:	Radiology:
<input type="checkbox"/> Myelopathy or spasticity	<input type="checkbox"/> Neoplastic malignant	<input type="checkbox"/> Cord signal change/syrinx/cavitation
<input type="checkbox"/> Numbness, perianal and both legs Dermatomal distribution:	<input type="checkbox"/> Acute high impact trauma	<input type="checkbox"/> Instability
<input type="checkbox"/> Weakness – arm/leg Myotomal distribution:	<input type="checkbox"/> Infection	<input type="checkbox"/> Spinal cord compression
<input type="checkbox"/> Pain/Numbness – arm or leg Predominant side: Right / Left / Bilateral	<input type="checkbox"/> Neoplastic benign	<input type="checkbox"/> Spondylolisthesis
<input type="checkbox"/> Neurogenic claudication	<input type="checkbox"/> Congenital	<input type="checkbox"/> Severe canal stenosis
<input type="checkbox"/> Midline pain neck or back	<input type="checkbox"/> Degenerative / Arthritic	<input type="checkbox"/> Deformity
<input type="checkbox"/> None of the above	<input type="checkbox"/> Remote or Low impact trauma	<input type="checkbox"/> Root compression
	<input type="checkbox"/> None of the above	<input type="checkbox"/> Moderate canal stenosis
		<input type="checkbox"/> Foraminal narrowing
		<input type="checkbox"/> None of the above

Dominant symptoms

Neck Low back Limb (arm/leg)

Provisional diagnosis**Previous Spinal Injections****Response** Epidural Nil Short-term Sustained Nerve block (foraminal) Nil Short-term Sustained Facet joint Nil Short-term Sustained**Pain medication used** Simple Analgesia Opioids Neuropathic agents**Additional information required****Investigations:**

Please attach copies of all relevant:

Xrays Scans Specialist reports

Past Medical History:

Please attach summary of:

Medical history/comorbidities (including BMI) Current medication list

Office use only (triage)

Clinical Score:

Category:

Date: / /

Signature:

Name and designation:

Fax to: (08) 8204 4059**Mail address:**

Outpatient Clinic C & D,
Level 2,
Flinders Medical Centre,
Bedford Park, SA 5042

Is this a re-referral? Yes No