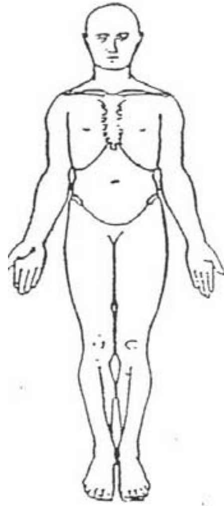
AMNCH SPINAL REFERRAL FORM

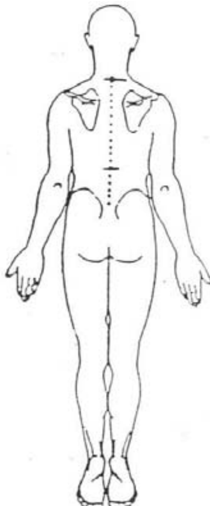
Patient Details
First Name ______________________________
Surname ________________________________
Hospital Number ________________________
Address ________________________________
____
____
Date of Birth ____/____/____
Phone No ________________________
Occupation ______________ Currently working? Yes □ No □ If not, for how long?______________
Is there a Medicolegal Claim Pending? Yes □ No □

GP Details
Name ____________________________
Address __________________________
____
____
Phone No _________________________
Signature _________________________

Clinical Presentation____
____
____
____

Please draw on the bodychart the area(s) where the patient is experiencing pain.
Mark with an **X** any areas of paraesthesia and/or numbness.





Radiation to Upper Limbs Yes □ No □
Below Elbow Yes □ No □

Radiation to Lower Limbs Yes □ No □
Below Knee Yes □ No □

Pain is worse in the Back □ Leg □
Neck □ Arm □

Duration of Symptoms	Back/Neck	Leg/Arm
Less than 6 weeks	□	□
6 weeks-3 months	□	□
4-6 months	□	□
7-12 months	□	□
> 1 year	□	□

Neurological Signs
Sensory Loss Yes □ No □ Level _______
Muscle Weakness Yes □ No □ Level _______
Altered Reflexes Yes □ No □ Level _______

Positive SLR R:______ L:______
If SLR limited, is this because of back pain □/ leg pain □

Results of Investigations: e.g. Xray, MRI, Bloods, Please attach results of relevant investigations
____
____
____

Drug Treatments:____
____

Relevant Medical History:____
____
____

Psychosocial risk factors: Anxiety, depression, fear-avoidance
for developing chronic disability present? Yes □ No □ If Yes, Please Outline______________________
____
____

****Please provide sufficient information to facilitate the appropriate triage categorisation for this patient****
Please fax completed forms to 01-4145889
Please phone 01-4145958 with any additional queries

Red Flags (i.e. indicators of possible serious spinal pathology) Yes □ No □
Saddle Anaesthesia Yes □ No □
Bladder/Bowel Disturbance Yes □ No □
If yes, a PR exam should be performed. If any sus
immediate referral to the Emergency Department is indicated.

- □ Sudden Unexplained Weight Loss
- □ Night Sweats
- □ Worsening Malaise
- □ Recent trauma
- □ Worsening Deformity
- □ Thoracic Pain
- □ PMHx of Cancer, Steroids, HIV
- □ Non Mechanical Pain
- □ Fever
- □ Haemarthrosis
- □ Raised ESR/CRP
- □ Night Pain (requiring the patient to get out of bed)

Inflammatory Presentation □ Yes □ No

- □ Better with exercise, worse with rest
- □ AM Stiffness > 30 min (______ Hrs)
- □ Multiple Joint Pain
- □ Alternating buttock pain
- □ Night Pain

History of

- □ Iritis/Uveitis
- □ Psoriasis
- □ Inflammatory Bowel Disease
- □ Urethritis
- □ Recent infection

Investigations: The following blood tests should be done in all patients with suspected inflammatory arthritis arthritis: E**SR, CRP**

Previous Treatments for Back Pain and Outcome:
(Ideally, unless urgent, your patient should access Physiotherapy Services prior to referral to this clinic)
Physiotherapy □ Yes □ No Outcome ____
____
____
____
Other Treatments (e.g. Surgery, Pain Injections, Acupuncture, Alternative Treatments)
____
____
____
Previous medications ____
Consultant Contact □ Yes □ No Outcome _______________________________________
Interpreter required (For non-English speaking patients) Yes □ No □ Language (Please Specify) ______________

GP Priority: Immediate □ Urgent □ Routine □
G.P. Destination: Ortho □ Pain □ Rheum □ BPSC □

For Office Use Only
Date Received in Triage Clinic: ___________
Date Processed: ___/___/___
Destination: Ortho □ Pain □ Rheum □ BPSC □
Categorisation: Cat A. □ Cat. B □ Cat. C □

****Please provide sufficient information to facilitate the appropriate triage categorisation for this patient****
Please fax completed forms to 01-4145889
Please phone 01-4145958 with any additional queries