Queensland Government

Royal Brisbane and Women's Hospital

SPINAL SURGICAL SERVICE REFERRAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Date referred: ..... / ..... / .....

Patient details (if no patient label)

Patient name: ..... Date of Birth: ..... / ..... / ..... Gender: .....

Spoken language (if other than English): ..... Interpreter required? ☐ Yes ☐ No

Address: .....

Home phone: ..... Work phone: ..... Mobile phone: .....

Referring doctor details

Referring doctor name: ..... Practice name: .....

Address: .....

Practice phone: ..... Fax number: .....

Clinical details – please complete in full as information is essential for accurate triage.

Region	☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Arm pain ☐ Leg pain Which is worse: ☐ Spine pain ☐ Limb pain

BMI:	Height:	Weight:

Does the patient present with red flag symptoms or motor radicular symptoms?

Red flag symptoms:

Unexplained weight loss	☐ Yes	☐ No
History of Ca, HIV or steroids	☐ Yes	☐ No
Systemically unwell	☐ Yes	☐ No
Constant unremitting pain/night pain	☐ Yes	☐ No
Significant trauma	☐ Yes	☐ No

Cauda Equina symptoms: Sensory Radicular symptoms:

Bladder retention	☐ Yes	☐ No
Bowel incontinence	☐ Yes	☐ No
Genital paraesthesia	☐ Yes	☐ No

(Consider referral to ED if sinister pathology likely)

Motor radicular symptoms:

Limb weakness or deep tendon reflex loss? ☐ Yes ☐ No

If yes, describe:

Numbness or paraesthesia? ☐ Yes ☐ No

If yes, describe:

Examination findings – please attach past medical history and investigations/ medical imaging reports:

Diagnosis:

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History of presenting condition:

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Main findings:

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Past spinal surgery: ☐ Yes ☐ No

If yes, please provide details:

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Conservative treatment trialled in the last year: ☐ Yes ☐ No

☐ Physio / Chiropractor ☐ Acupuncture ☐ Chronic disease management plan ☐ Dietetics ☐ Nil

If yes, please provide details:

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Does the patient have depression, anxiety or other relevant psychosocial factors: ☐ Yes ☐ No

If yes, please provide details:

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Is the patient off work due to current problems: ☐ Yes ☐ No

If yes, please provide details:

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Referring doctor's signature: ..... **Date:** ..../..../.....

DO NOT WRITE IN THIS BINDING MARGIN