

Patient Information

*Name:		OHIP#:	VC#:
<input type="radio"/> Female	Age:	*Date of Birth: mm/dd/yyyy	*Daytime Phone#: ()
<input type="radio"/> Male			
*Address:		*City:	*Postal Code:

Patient is eligible for Rapid Access Clinic - Low Back Pain (RAC - LBP) referral if over 18 years of age with:
 Persistent LBP and/or related symptoms (e.g., sciatica, neurogenic claudication) that is not improving 6 wks. to 12 mos. from onset
OR Unmanageable recurrent episodic LBP and/or related symptoms of <12 mos. duration post-recurrence.

IMPORTANT: Patient is ineligible for RAC - LBP referral if one or more of the conditions apply:

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Patient with RED FLAGS ▪ Initial low back related symptoms <6 weeks post onset ▪ Constant/persistent LBP-related symptoms >12 months post onset ▪ <18 years of age ▪ Unmanaged established chronic multisite pain disorder | <ul style="list-style-type: none"> ▪ Unmanaged established narcotic dependency ▪ Active LBP-related WSIB claim ▪ Active LBP-related motor vehicle accident claim ▪ Active LBP-related legal claim ▪ Pregnant/post-partum patients (<1 year) |
|---|---|

Reason for referral: (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Clarify diagnosis | <input type="checkbox"/> Recommend further treatment |
| <input type="checkbox"/> Recommend appropriate imaging | <input type="checkbox"/> Clarify activity limitations / restrictions |
| <input type="checkbox"/> Clarify need for specialist referral | <input type="checkbox"/> Other, please specify: _____ |

Back Specific History

<p>1. Where has the pain / symptoms been the worst? (Check one)</p> <p><input type="radio"/> Back Dominant <input type="radio"/> Leg Dominant</p>	<p>3. *Is there a previous history of back problems?</p> <p><input type="radio"/> No <input type="radio"/> Yes. Describe: _____</p> <p>_____</p>
--	---

<p>2. *Are emergent RED FLAGS present?</p> <ul style="list-style-type: none"> ▪ Possible Cauda Equina Syndrome: <ul style="list-style-type: none"> ▪ Loss of anal sphincter tone/ fecal incontinence ▪ Saddle anaesthesia about anus, perineum, or genitals ▪ Urinary retention with overflow incontinence ▪ Progressive neurologic deficit ▪ Significant trauma <p><input type="radio"/> No</p> <p><input type="radio"/> Yes. Please refer patient directly to the closest Emergency.</p>	<p>4. *Previous investigations, treatment or surgery for back problems?</p> <p><input type="radio"/> No <input type="radio"/> Yes. Describe: _____</p> <p>_____</p>
--	--

	<p>5. Relevant co-morbidities / Comments:</p> <p>_____</p> <p>_____</p>
--	--

	<p>Does the patient have any YELLOW FLAGS?</p> <p><input type="checkbox"/> Belief that pain is harmful or severely disabling</p> <p><input type="checkbox"/> Fear avoidance behaviour (avoiding activity because of fear of pain)</p> <p><input type="checkbox"/> Low mood and social withdrawal</p> <p><input type="checkbox"/> Expectation that passive treatment rather than active treatment will help</p>
--	---

Does the patient speak:

English French Neither. If patient does not speak either English or French, we recommend they bring a translator.

I hereby refer the above noted patient to RAC - LBP and a physician specialist as appropriate.

*Referring Practitioner Name:	*Billing#:	*CPSO#/CNO#:
*Practitioner Address:	*Fax#: ()	
Practitioner Signature:	*Date of Referral: mm/dd/yyyy	