Mater Misericordiae University Hospital
Sub-acute Spinal Pain Referral

Referring GP Practice: _____
_____

Referring Doctor:_____
Practice Phone:_____

PATIENT DETAILS:

Surname: Forename:

Date of Birth: Sex: Male ☐ Female ☐

Interpreter Necessary: Yes ☐ No ☐ If yes, state language:

Address:

Home Phone: Mobile Phone:

CLINICAL DETAILS: Please complete in full as information essential for accurate triage

Region	☐ Neck pain ☐ Back pain ☐ Arm Pain ☐ Leg Pain Which is worse: ☐ Spine Pain ☐ Limb Pain
BMI	Height: Weight: BMI:

RED FLAGS AND NEUROLOGICAL SYMPTOMS:

'Red Flags'

☐ Unexplained weight loss (>10% body weight in 3-6/12)

☐ History of Cancer/HIV/ Immunosuppression

Details:

☐ Severe Unremitting Night Pain

☐ Gait Disturbance

☐ Fever

Cauda Equina Symptoms:

Bladder Retention	☐ Yes	☐ No
Bowel Incontinence	☐ Yes	☐ No
Genital paraesthesia	☐ Yes	☐ No

If clinical concern of cauda equina syndrome, then refer directly to local ED for urgent MRI

Neuro Signs Lumbar Spine/Lower Limbs (LL)

☐ LL sensory disturbance

☐ LL weakness

☐ Altered Reflex

Describe: _____
_____

Neuro Signs Cervical Spine/Upper Limbs (UL)

☐ UL Sensory Disturbance ☐ Dizziness ☐ Severe & Constant Headache

☐ UL Motor Weakness ☐ Fine motor skill deficit (eg tying laces/buttons)

☐ UL/LL Altered Reflex ☐ Double Vision

Describe:_____
_____

Inflammatory Presentation

☐ Night Pain ☐ Multiple joint pain ☐ Morning stiffness ☐ Resting pain, improved with exercise

History of: ☐ Iritis ☐ Psoriasis ☐ Inflamm bowel disease ☐ Fam Hx of inflamm disease

CURRENT EPISODE OF SPINAL PAIN:

Duration of Symptoms ☐ <6/52 ☐ 6/52-6/12 ☐ 6/12-1year ☐ >1 year

☐ Acute 1st Episode ☐ Acute Exacerbation of Chronic Condition

Onset: ☐ Spontaneous ☐ Following minor injury/strain ☐ Following Major Injury

Is patient off work due to this problem? ☐ Yes ☐ No If Yes, how long?

History of previous spinal surgery? ☐ Yes ☐ No If Yes, details:

Is there an on-going medicolegal case pertaining to the current problem? ☐ Yes ☐ No

RELEVANT INVESTIGATIONS:

☐ X-Ray ☐ Report Attached
☐ MRI ☐ Report Attached
☐ Blood tests ☐ Report Attached
☐ Other Please state:_____

CONSERVATIVE TREATMENT IN LAST YEAR:

☐ Physiotherapy ☐ Osteopathy/Chiropractic
☐ Department of Pain Medicine Input
☐ Other Please state:_____
_____

RELEVANT PAST MEDICAL HISTORY:

Smoker ☐ Yes ☐ No

Does the patient have depression, anxiety or other relevant psychosocial factors? ☐ Yes ☐ No
If Yes, please give details:

MEDICATION:

What is the overall level of disability?

☐ No limitations ☐ Mild Limitations (able to do most activities with minor modifications)

☐ Moderate Limitations (able to do most activities with modifications)

☐ Severe Limitations (unable to perform most activities)

What clinical question do you want answered by this referral?

FOR HOSPITAL USE ONLY:

Paper Triage Outcome:

☐ Consultant Appointment ☐ MSK Triage Appointment ☐ Refer to Physiotherapy

☐ Routine WL (N/A for pilot) ☐ Return to Referrer Reason _____