# Association of Dalhousie Neurosurgeons
# ELECTIVE SPINE REFERRAL FORM
# Please FAX to: (902) 425-4789

| Patient | Referring Physician |
|---|---|
| Date: | Referring Physician Name: |
| Patient Name: | |
| Address: | Address: |
| Telephone: | |
| D.O.B.: | |
| Health Card Number #: | Phone: |
| **History of Presenting Illness:** | Fax: |

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| Pain: Onset/Time course: |
| Location: |
| Quality: |
| Radiation: |
| Aggravating Factors: |
| Relieving Factors: |
| Severity: /10(best) /10(average) /10(worst) |

| Previous Treatment: | Past Medical History: |
|---|---|
| ☐ physiotherapy ☐ chiropractic | ☐ related trauma ☐ infection/inflammatory |
| ☐ acupuncture ☐ massage | ☐ cancer - specify ________________________. |
| ☐ surgery (specify): | ☐ congenital spine abnormality |
| Medications: | Neurogenic Bowel ☐ Y ☐ N<br>Neurogenic Bladder ☐ Y ☐ N |

***** PLEASE ATTACH AVAILABLE IMAGING REPORTS *****

**Physical Exam: please provide exam appropriate to referral (i.e. cervical or lumbar)**
**Blank sections considered "Normal"**

| Motor Exam (MRC 1-5; Normal=5) | R | L | Deep Tendon Reflexes (Normal=2) | R | L | Sensory Exam (0=absent, 1=abnormal, 2=normal) | R | L | Mechanical Signs (+/-) | R | L |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Shoulder Abduct (C5) | | | Biceps | /4 | /4 | C5 | | | Spurling | | |
| Elbow Flex (C5,6) | | | Brachioradialis | /4 | /4 | C6 | | | Straight Leg Raise | | |
| Wrist Ext (C6) | | | Triceps | /4 | /4 | C7 | | | | | |
| Elbow Ext (C7) | | | Knee Jerk | /4 | /4 | C8 | | | | | |
| Finger Flex (C8) | | | Ankle Jerk | /4 | /4 | T1 | | | | | |
| Finger Abduct(T1) | | | Clonus (Y/N) | | | L2 | | | | | |
| Hip Flex (L2) | | | Babinski (up/down) | | | L3 | | | | | |
| Knee ext (L3) | | | Rectal Tone (Normal/ Reduced) | | | L4 | | | | | |
| Dorsiflex (L4) | | | | | | L5 | | | | | |
| Extensor Hallucis Longus (L5) | | | | | | S1 | | | | | |
| Plantar Flex (S1) | | | | | | Peri-anal | | | | | |

SENSORY
KEY SENSORY POINTS