WINNIPEG SPINE PROGRAM

Tel: 204-787-7267
Fax: 204-783-7356
WinnipegSpineProgram@umanitoba.ca

Spine referral form

Date OF Referral:_____

□ Preferred Surgeon _____

Referral overview: objective physical and neurological examination & all subjective complaints.
To ensure prompt and appropriate referral of your patient, please complete this form and include all of the patient's complete spine history and relevant details.
This data is important to ensure appropriate patient prioritization.

Referrals will not be assessed without this information and will be returned to sender.

Patient demographics:

Last name:_____ First:_____

Gender: □ Female □ male Dob: (dd/mm/yyyy) _____

MHSC#_____ phin#_____

Tel: (Home)_____(Work)_____(Other)_____

Address_____

City_____Province_____Postal Code_____

Referral Type:

- o New
- o Repeat
- o WCB
- o WCB Appeal
- o MPIC
- o 2nd Opinion
- o Medical Legal

Referring Physician: _____

Address:_____

_____

Phone: _____

Fax: _____

Winnipeg spine program surgeons

Section of Neurosurgery

GB1-820Sherbrook St.
Winnipeg MB R3A 1R9

Dr. Neil Berrington
Assistant Professor
Neurosurgery
Tel: 204-787-7276

Dr. Perry Dhaliwal
Director, Winnipeg spine fellowship program
Assistant professor
Neurosurgery
Tel: 204-787-7296

Dr. Gregory Hawryluk
Assistant Professor
Neurosurgery
204-787- 7270

Section of Orthopedics

AD4-820 Sherbrook St.
Winnipeg, MB R3A 1R9

Dr. Michael Johnson
Assistant Professor
Adult and Pediatric Orthopedics & Neurosurgery
Tel: 204-787-4415

Dr. Michael Goytan
Associate Professor
Adult and Pediatric Orthopedics & Neurosurgery
Tel: 204-787-1913

Dr. Mohammad Zarrabian Assistant Professor Adult Orthopedics Tel: 204-787-4773

Reason for referral:

- ☐ Tumor
- ☐ Infection
- ☐ Fracture
- ☐ Myelopathy

- ☐ Neck
  - o Radiation into forearms and hands
  - o Numbness, tingling, or weakness
  - o Clumsy hands or feet
- ☐ Back Pain:
  - o Radiation into legs below the knee
  - o Numbness, tingling, or weakness
  - o Clumsy hands or feet
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Weakness:_____

Previous Surgery:

_____

Previous Management:

_____

Additional Significant Findings:

_____

_____

_____

- o Scoliosis:
  - o Adult Degree _____
  - o Child Degree_____

Symptom Duration

- ☐ <3 months
- ☐ 3-6 months
- ☐ 6 - 12 months
- ☐ >1 year

Spine Region:

- ☐ Occipital
- ☐ Occipitocervical
- ☐ Cervical
- ☐ Cervicothoracic
- ☐ Thoracic
- ☐ Thoracolumbar
- ☐ Lumbar
- ☐ Lumbosacral
- ☐ Sacral

Spine Radiology:

- ☐ Plain XR Date:_____ Location: _____
- ☐ CT scan Date:_____ Location: _____
- ☐ MRI Date:_____ Location: _____
- o CT/Myelogram Date:_____ Location: _____
- ☐ Bone scan Date:_____ Location: _____

****It is not necessary to order any radiological tests unless specifically requested by Spine Program****

Please send completed referral to FAX# 204.783.7356