



SPINE REFERRAL FORM

- NEXT AVAILABLE SURGEON
- 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:

***REFERRING PHYSICIAN:** _____

NEW

REPEAT ADDRESS: _____

WCB

WCB APPEAL PHONE: _____

MPIC FAX: _____

2ND OPINION

MEDICAL LEGAL

WINNIPEG SPINE PROGRAM SURGEONS

SECTION OF NEUROSURGERY

GB1-820 SHERBROOK ST.
WINNIPEG MB R3A 1R9

DR. NEIL BERRINGTON
HEAD, WINNIPEG SPINE
PROGRAM
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

PREVIOUS SURGERY:

PREVIOUS MANAGEMENT:

- NECK
 - RADIATION INTO FOREARMS AND HANDS
 - NUMBNESS, TINGLING, OR WEAKNESS
 - CLUMSY HANDS OR FEET

ADDITIONAL SIGNIFICANT FINDINGS:

- BACK PAIN:
 - RADIATION INTO LEGS BELOW THE KNEE
 - NUMBNESS, TINGLING, OR WEAKNESS
 - CLUMSY HANDS OR FEET

- ARM PAIN
- LEG PAIN
- WEAKNESS: _____

SCOLIOSIS:

ADULT DEGREE _____

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: _____
- 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**