RAC LBP RAPID ACCESS CLINICS FOR LOW BACK PAIN

**CENTRAL EAST**
**FAX TO: 1-833-222-9065**

Ontario

## *Patient Information*

| | | | |
|---|---|---|---|
| *Name: | | | OHIP#: VC#: |
| ◯ Female ◯ Male | Age: | *Date of Birth: mm/dd/yyyy | *Daytime Phone#: ( ) |
| *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:*

- 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
- 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)

☐ Clarify diagnosis
☐ Recommend appropriate imaging
☐ Clarify need for specialist referral
☐ Recommend further treatment
☐ Clarify activity limitations / restrictions
☐ Other, please specify: _____

## *Back Specific History*

**1. Where has the pain / symptoms been the worst? (Check one)**

◯ Back Dominant ◯ Leg Dominant

**2. *Are emergent RED FLAGS present?**

- **Possible Cauda Equina Syndrome:**
  - Loss of anal sphincter tone/ fecal incontinence
  - Saddle anaesthesia about anus, perineum, or genitals
  - Urinary retention with overflow incontinence
- **Progressive neurologic deficit**
- **Significant trauma**

◯ No
◯ Yes. **Please refer patient <u>directly</u> to the closest Emergency.**

**3. *Is there a previous history of back problems?**

◯ No ◯ Yes. Describe: _____

**4. *Previous investigations, treatment or surgery for back problems?**

◯ No ◯ Yes. Describe: _____

**5. Relevant co-morbidities / Comments:**

_____

**Does the patient have any YELLOW FLAGS?**

☐ Belief that pain is harmful or severely disabling
☐ Fear avoidance behaviour (avoiding activity because of fear of pain)
☐ Low mood and social withdrawal
☐ Expectation that passive treatment rather than active treatment will help

Does the patient speak:
☐ English ☐ French ☐ Neither. If patient does not speak English, 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 | |