

Patient Information

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

<input type="checkbox"/> Clarify diagnosis	<input type="checkbox"/> Recommend further treatment
<input type="checkbox"/> Recommend appropriate imaging	<input type="checkbox"/> Clarify activity limitations / restrictions
<input type="checkbox"/> Clarify need for specialist referral	<input type="checkbox"/> Other, please specify: _____

Back Specific History

<p>1. Where has the pain / symptoms been the worst? (Check one)</p> <p><input type="checkbox"/> Back Dominant <input type="checkbox"/> Leg Dominant</p>	<p>3. *Is there a previous history of back problems?</p> <p><input type="checkbox"/> No Yes. Describe: _____</p> <p>_____</p>
<p>2. *Are emergent RED FLAGS present?</p> <ul style="list-style-type: none"> ▪ Possible Cauda Equina Syndrome: <ul style="list-style-type: none"> ▪ Loss of anal sphincter tone/ fecal incontinence ▪ Saddle anaesthesia about anus, perineum, or genitals ▪ Urinary retention with overflow incontinence ▪ Progressive neurologic deficit ▪ Significant trauma <p>No</p> <p>Yes. Please refer patient <u>directly</u> to the closest Emergency.</p>	<p>4. *Previous investigations, treatment or surgery for back problems?</p> <p>No Yes. Describe: _____</p> <p>_____</p> <p>5. Relevant co-morbidities / Comments:</p> <p>_____</p> <p>Does the patient have any YELLOW FLAGS?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Belief that pain is harmful or severely disabling <input type="checkbox"/> Fear avoidance behaviour (avoiding activity because of fear of pain) <input type="checkbox"/> Low mood and social withdrawal <input type="checkbox"/> 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	