

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

Does the patient speak:  
 English French  Neither. If patient does not speak either English or French, 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	