

<b>Patient Information</b>			
*Name:		*OHIP#:	
<input type="checkbox"/> Female    Age:		*Daytime Phone#:	
<input type="checkbox"/> Male		*Date of Birth:    yyyy-mm-dd	
*Address:		*City:	*Postal Code:
<b>Patient is eligible for Rapid Access Clinic - Low Back Pain (RAC - LBP) referral if over 18 years of age with:</b> Patients w/ persistent LBP and/or related symptoms (e.g., sciatica, neurogenic claudication) that is not improving 6 wks. to 12 mos. from onset <b>OR</b> Patients w/ unmanageable recurrent episodic LBP and/or related symptoms of <12 mos. duration post-recurrence.			
<b>IMPORTANT: Patient is ineligible for RAC - LBP referral if one or more of the conditions apply:</b>			
<ul style="list-style-type: none"> <li>▪ Patient with RED FLAGS</li> <li>▪ Initial low back related symptoms &lt;6 weeks post onset</li> <li>▪ Constant/persistent LBP-related symptoms &gt;12 months post onset</li> <li>▪ &lt;18 years of age</li> <li>▪ Unmanaged established chronic multisite pain disorder</li> </ul>		<ul style="list-style-type: none"> <li>▪ Unmanaged established narcotic dependency</li> <li>▪ Active LBP-related WSIB claim</li> <li>▪ Active LBP-related motor vehicle accident claim</li> <li>▪ Active LBP-related legal claim</li> <li>▪ Pregnant/post-partum patients (&lt;1 year)</li> </ul>	
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:	
<b>Back Specific History</b>			
<b>1. Where has the pain / symptoms been the worst? (Check one)</b>  <input type="checkbox"/> Back Dominant <input type="checkbox"/> Leg Dominant		<b>3. *Is there a previous history of back problems?</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:	
<b>2. *Are emergent RED FLAGS present?</b>  <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> <input type="checkbox"/> No <input type="checkbox"/> Yes. <b>Please refer patient directly to the closest Emergency.</b>		<b>4. *Previous investigations, treatment or surgery for back problems?</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes. Describe:	
<b>5. Relevant co-morbidities / Comments:</b>			
<b>Does the patient have any YELLOW FLAGS?</b> <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: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Neither. If patient does not speak either English or French, we recommend they bring a translator.			
<b>I hereby refer the above noted patient to RAC - LBP and a physician specialist as appropriate.</b>			
*Referring Practitioner Name:		*Billing#:	*CPSO#/CNO#:
*Practitioner Address:		*Fax#:	
Practitioner Signature:		*Date of Referral:	