

**Association of Dalhousie Neurosurgeons**  
**ELECTIVE SPINE REFERRAL FORM**  
Please FAX to: (902) 425-4789

Date:	Referring Physician Name:  Address:  Phone: Fax:
Patient Name:	
Address:	
Telephone:	
D.O.B.:	
Health Card Number #:	
<b>History of Presenting Illness:</b>	


Pain: Onset/Time course:
Location:
Quality:
Radiation:
Aggravating Factors:
Relieving Factors:

Severity:            /10(best)                            /10(average)                            /10(worst)	
Previous Treatment: <input type="checkbox"/> physiotherapy <input type="checkbox"/> chiropractic <input type="checkbox"/> acupuncture <input type="checkbox"/> massage <input type="checkbox"/> surgery (specify):	Past Medical History: <input type="checkbox"/> related trauma <input type="checkbox"/> infection/inflammatory <input type="checkbox"/> cancer - specify _____ <input type="checkbox"/> congenital spine abnormality
Medications:	Neurogenic Bowel <input type="checkbox"/> Y <input type="checkbox"/> N Neurogenic Bladder <input type="checkbox"/> Y <input type="checkbox"/> N

**\*\*\* PLEASE ATTACH AVAILABLE IMAGING REPORTS \*\*\***

**Physical Exam: please provide exam appropriate to referral (i.e. cervical or lumbar)**  
**Blank sections considered "Normal"**

Motor Exam (MRC 1-5; Normal=5)	R	L	Deep Tendon Reflexes (Normal=2)	R	L	Sensory Exam (0=absent, 1=abnormal, 2=normal)	R	L	Mechanical Signs (+/-)	R	L
Shoulder Abduct (C5)			Biceps	/4	/4	C5			Spurling		
Elbow Flex (C5,6)			Brachioradialis	/4	/4	C6			Straight Leg Raise		
Wrist Ext (C6)			Triceps	/4	/4	C7			<p align="center"><b>SENSORY</b> KEY SENSORY POINTS</p>		
Elbow Ext (C7)			Knee Jerk	/4	/4	C8					
Finger Flex (C8)			Ankle Jerk	/4	/4	T1					
Finger Abduct(T1)			Clonus (Y/N)			L2					
Hip Flex (L2)			Babinski (up/down)			L3					
Knee ext (L3)			Rectal Tone (Normal/ Reduced)			L4					
Dorsiflex (L4)				L5							
Extensor Hallucis Longus (L5)				S1							
Plantar Flex (S1)						Peri-anal					