Brenda & David McLean Integrated Spine Clinic Blusson Spinal Cord Centre

2nd Floor, 818 West 10th Avenue, Vancouver

Phone: 604-875-4992

Please fax <u>complete</u> referral to: 604-875-5858

* Please note that all medical records/history and films must be sent with referral.

WSBC cases to be referred to VSC Richmond Fax 604-233-9777

If patient presents with any of these symptoms, please contact spine	
surgeon on-call through VGH switchboard	

Telephone:

PATIENT INFORM PHN #:	ATION/ LABEL						
LAST NAME:							
FIRST NAME:							
GENDER:		☐ FEMALE					
DATE OF BIRTH:			AGE:				
ADDRESS:							
PREFERRED CONTACT #:							
EMAIL:							

- Recent onset bowel/bladder dysfunction/incontinence/cauda equina
- Recent history of severe trauma i.e. Motor vehicle accident, fall

surgeon on-call through VGH switchboard REASON FOR REFERRAL Primary Complaint/Clinical Concern:							
Examination Finding	s:						
PRESENTING SIGNS 8	& SYMPTOMS (plea	ase indicate on diagram)		\cap			
Weakness	☐ Stable	\square Worsening		X	If patient has weakness, numbness/		
Numbness/Tingling	☐ Stable	\square Worsening			tingling or extremity pain, please have current axial imaging		
Pain	☐ Stable	\square Worsening)_/_((CT/MRI) completed		
Other (specific))/ \(and results included with this referral		
Duration:	☐ Less than 6	weeks Between 6-12 we	eks 🗆 More than 1	12 weeks (please specify) _			
· · · · · · · · · · · · · · · · · · ·	•	ck problems?					
-		k or neck problems? 🛭 Y					
Is this a 2 nd Opinion?	Explain:						
What is the overall level of disability?							
	se indicate investigat CT Scan	ions done and forward results IRI □ Bone Scan	r/films with referral) ☐ EMG	☐ Performed at VGH☐ Other:			
REFERRING PHYSICIAN Stamp or Complete	Name: MSP #:		Date: Special	ty:			

Fax: