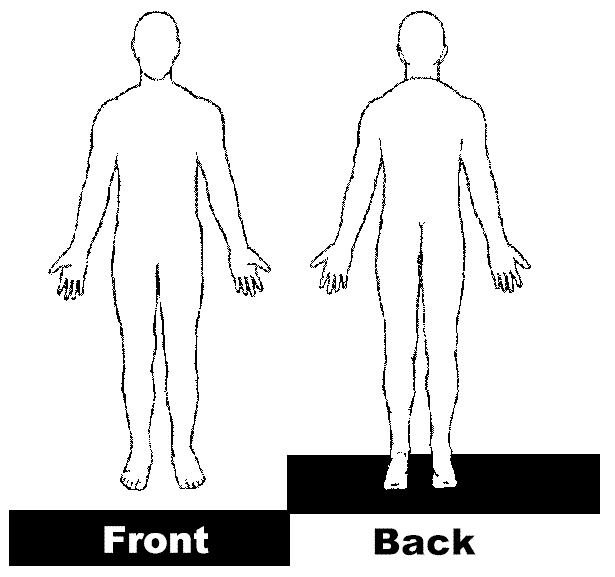
**GENERAL PRACTITIONER REFERRAL TO NEUROSURGERY SPECIALIST CLINIC**

**BACK AND NECK SUPPORTING CLINICAL INFORMATION FORM**

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| **PATIENT INFORMATION**  Western health ur (if known): |
| Title First name: Surname: |
| Sex DOB: |
| Address: |
| Contact numbers—home: mobile: |
| Interpreter required: yes/no:  Preferred Language: |

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| --- |
| **REFERRER DETAILS** |
| Name: |
| Clinic name |
| Address: |
| Phone: |
| Fax: |
| Provider number |

**INDICATE AREA(S) OF SYMPTOMS PRIORITY SIGNS OF NEUROLOGICAL SYMPTOMS**



|  |  |  |  |
| --- | --- | --- | --- |
| 1 | WEAKNESS  If yes, list weak muscle groups | Yes | No |
| 2 | SENSORY LOSS | Yes | No |
| 3 | URINARY/BOWEL DYSFUNCTION PERIANAL SENSORY LOSS | Yes | No |
| 4 | LOSS OF REFLEX  If yes, which reflex | Yes | No |
| 5 | HYPER-REFLEXIA | Yes | No |
| 6 | ATAXIA | Yes | No |
| 7 | PLANTAR REFLEX | Yes | No |
| 8 | CLONUS | Yes | No |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Many types of low back/leg pain and neck/arm pain will respond to a range of CONSERVATIVE treatments. In order to prevent acute pain becoming chronic, these conservative options should be explored first unless the involvement of neurological signs is more profound.  **THE EXPECTATION IS THAT TREATMENTS HAVE BEEN TRIALLED AS PART OF THE MANAGEMENT HISTORY**  **Treatments have been trialled as part of management history** | | | | | | |
| Exercise | | Yes/Time | | | | No |
| Physiotherapy | | Yes/Time | | | | No |
| Weight loss | | Yes/Time | | | | No |
| Anti-inflammatory medication | | If yes, Name & timeframe | | | | No |
| Other | | Please specify | | | | |
| **Functional limitation (closest response)** | | | | | | |
| Walking | | | <50m | 50-100m | >500m | |
| Sitting duration | | | <5 mins | 5-15 mins | >15 mins | |
| Sleep significantly disturbed | | | | Yes | No | |
| BMI |  | | | | | |

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| ***PLEASE BE AWARE THAT 90-95% OF REFERRALS TO NEUROSURGERY DO NOT REQUIRE SURGICAL INTERVENTION. NEUROSURGERY SPECIALTY IS A SURGICAL CLINIC*** |

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| **HISTORY OF CURRENT CONDITION (ALSO ATTACH REFERRAL LETTER)** |
| Date of onset |
| Pain duration (include pain score: Visual Analogue Scale 0 – 10) |
| Radicular arm/leg pain |
| Neurological involvement |
| Current medication |
| Current/Previous management for this condition |