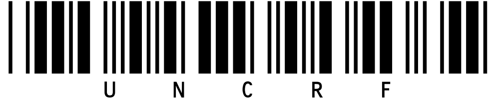

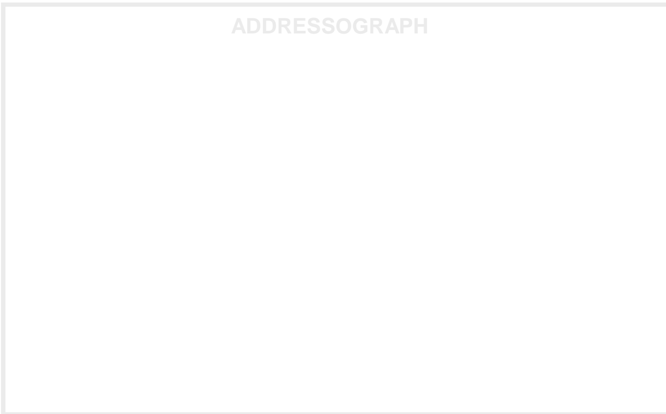

U N C R F

WINDSOR NEUROSURGERY AND SPINE ASSOCIATES

URGENT NEUROSURGICAL CLINIC REFERRAL FORM

FAX: 519-973-5572

IF FORM IS NOT FULLY COMPLETED, IT WILL BE RETURNED WITHOUT PROCESSING.

Date of referral ______________________________

Patient's Name: ______________________________ DOB: ______________________________

Phone: ______________________________ Referring Physician: ______________________________

Family Physician: ______________________________ Referring Physician Phone: ______________________________

WAS THIS PATIENT SEEN IN THE EMERGENCY DEPARTMENT? FACILITY______________________________

Was Neurosurgeon Contacted: ❒ Yes ❒ No Neurosurgeon Name: ______________________________

REASON FOR REFERRAL: (please include sufficient information to allow for appropriate triage)

____

____

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ALL OF THE SECTIONS BELOW MUST BE COMPLETED FOR AN ACCURATE TRIAGE AND PROCESSING

SPINAL RED FLAGS (For Clinic Triage Purposes) ❒ NONE

❒ Bowel/Bladder incontinence ❒ Saddle Anesthesia ❒ Extremity Weakness ❒ New Foot Drop ❒ Fever
❒ Muscle Wasting ❒ Inability to use hand ❒ History of cancer

BRAIN RED FLAGS (**For Clinical Triage Purposes**) ❒ NONE
❒ New onset headaches ❒ Severe pain with chewing ❒ New onset seizures ❒ Memory changes ❒ Personality change
❒ History of cancer ❒ Changes in speech ❒ Changes in vision

PERTINENT NEUROLOGICAL EXAM FINDINGS ❒ NORMAL NEUROLOGICAL EXAM

❒ Pupil examination: ______________________________ ❒ Abnormal Cranial Nerve Exam______________________________
❒ Mini Mental ______________________________
❒ Papilledema ❒ Pronator Drift ❒ Positive Romberg ❒ Visual Changes ❒ Gait disturbance ❒ Weakness or Motor loss

CONSERVATIVE TREATMENTS TO ALLEVIATE PAIN ALREADY TRIED: ❒ None

❒ Physiotherapy ❒ Massage therapy ❒ Aquatherapy ❒ TENS ❒ Anti-inflammatories
❒ Epidural Injection ❒ Facet injection ❒ Acupuncture ❒ Chiropractor

PLEASE INDICATE BELOW THE TESTING THAT HAS BEEN COMPLETED AND ATTACH THE REPORT WITH THIS REFERRAL.
(MRI Note: Contrast required if previous spinal surgery)

MRI: ______________________________ MRA: ______________________________ CT Scan: ______________________________

Bone Scan: ______________________________ X-Rays: ______________________________ EMG: ______________________________

IF THIS FORM IS NOT FULLY COMPLETED, IT WILL BE RETURNED WITHOUT PROCESSING

If during the wait for appointment your patient's condition changes or deteriorates please call Urgent Neurosurgical Clinic at 519-973-4411 ext 33695

Referring MD signature: ______________________________ Fax # ______________________________