WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

WINDSOR NEUROSURGERY AND SPINE ASSOCIATES

PATIENT LABEL

URGENT NEUROSURGICAL CLINIC REFERRAL FORM

Complete this form, then fax to 519-973-5572
IF FORM IS NOT FULLY COMPLETED, IT WILL BE RETURNED WITHOUT PROCESSING

Patient's Information	Referring Physician's Information
Patient's Name: _____	Date of Referral (mm/dd/yyyy): _____
Phone #: _____	Name: _____
DOB (mm/dd/yyyy):_____	Phone #: _____ Fax #: _____
Family Physician's Name:_____	Signature: _____

Was patient seen in the Emergency Department? ☐ No ☐ Yes, list facility's name:_____
Was Neurosurgeon Contacted? ☐ No ☐ Yes, list Neurosurgeon's Name: _____

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

_____
_____
_____

PLEASE INDICATE BELOW THE TESTING THAT HAS BEEN COMPLETED & ATTACH REPORT WITH REFERRAL

⚠ Note an MRI is required for all spine/ tumor referrals (not including fractures). An appointment will not be booked until imaging has been completed

MRI (mm/dd/yyyy): _____ CT Scan (mm/dd/yyyy): _____ Bone Scan (mm/dd/yyyy): _____
X-Ray (mm/dd/yyyy): _____ MRA (mm/dd/yyyy): _____ EMG (mm/dd/yyyy): _____

ARE EMERGENT FLAGS PRESENT?

⚠ **IF YES TO ANY OF THE BELOW, REFER PATIENT DIRECTLY TO THE CLOSEST EMERGENCY**

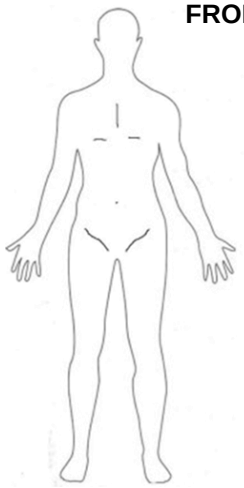
☐ **Possible Cauda Equina Syndrome:**
- Loss of anal sphincter tone/ fecal incontinence
- Saddle anesthesia at anus, perineum or genitals
- Urinary retention with or without overflow incontinence

☐ **Progressive Neurologic Deficit**

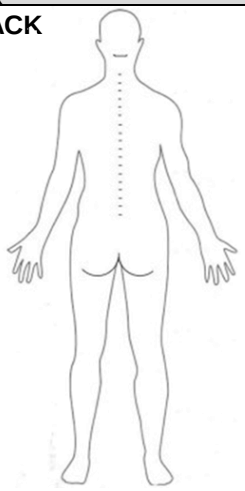
☐ **Significant Physical Trauma**

SPINAL RED FLAGS (Indicate the Area and Symptoms of weakness)

FRONT



BACK



Check if appropriate
☐ Fine motor skills dysfunction
☐ Bowel/ bladder dysfunction
☐ Babinski/ Clonus/ Hoffmans
☐ Immobility requiring aids? (wheelchair/ walker/ crutches)
☐ Focal/ myotomal weakness
☐ Spasticity?
☐ Saddle anesthesia?
☐ Known malignancy?
☐ Fevers/ rigors?
☐ Unexplained weight loss?

For Clinic Triage Purposes

SPINAL RED FLAGS

☐ None

BRAIN RED FLAGS

☐ None
☐ New onset headaches
☐ Severe pain with chewing
☐ New onset seizures
☐ Memory changes
☐ Personality Changes
☐ History of cancer
☐ Changes in speech
☐ Changes in vision

Symptom Duration

☐ < 6 wks	☐ 6-12 wks	☐ 3-9 mos	☐ 9-18 mos	☐ >18 mos

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CONSERVATIVE TREATMENTS TO ALLEVIATE PAIN ALREADY TRIED				
⚠ **If conservative treatment not tried, please attempt prior to sending referral**				
Treatment	**Response**			
Physical Therapy	☐ Not Tried	☐ Tried but no improvement	☐ Tried with some improvement	☐ Treatment Effective
Injections	☐ Not Tried	☐ Tried but no improvement	☐ Tried with some improvement	☐ Treatment Effective
Lyrica or Gabapentin	☐ Not Tried	☐ Tried but no improvement	☐ Tried with some improvement	☐ Treatment Effective

Referring Physician's Signature

_____	_____	_____
Date of Referral (mm/dd/yyyy)	Name (Print)	Signature

⚠ **If during the wait for an appointment your patient condition changes, call the Urgent Neurosurgical Clinic at 519-254-5577 ext. 33695.**

⚠ **If patient's condition deteriorates, please send to the closest Emergency.**

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