Orthopedic Associates

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Primary Care Practitioner Assessment and Referral Form

FAX to 780-833-8383

PATIENT INFORMATION

Last Name: _____ First Name: _____
Title: _____ ☐ Female ☐ Male
ULI: _____ DOB (MM/DD/YYYY): _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Tel: _____ Work: _____ Cell: _____

REASON FOR REFERRAL

****Note: ALL patients must have attempted non-operative treatment and have an *MRI DATED WITHIN THE LAST 18 MONTHS***

Primary Complaint/Clinical Concern: _____

PRESENTING SIGNS AND SYMPTOMS (select all that apply)

Is there a previous history of back problems?

☐ No ☐ Yes (Describe): _____

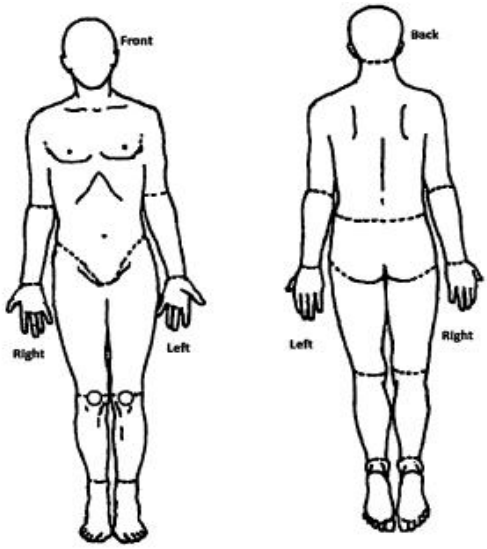
Has there been previous surgery for back or neck problems?

☐ No ☐ Yes (Describe): _____

What is the overall level of disability?

- ☐ No Limitations
- ☐ Mild Limitations - able to do most activities with minor modifications
- ☐ Moderate Limitations - able to do most activities with modification
- ☐ Severe Limitations - unable to perform most activites

PAIN DRAWING - Mark distribution of pain, paraesthesia, numbness



INVESTIGATIONS (MUST BE ATTACHED)

- ☐ MRI (MANDATORY)
- ☐ X-ray
- ☐ CT Scan
- ☐ Bone Scan
- ☐ EMG

NON-OPERATIVE TREATMENT (MANDATORY)

- ☐ PHYSIO
- ☐ CHIROPRACTOR
- ☐ INJECTIONS

REFERRING PHYSICIAN: (stamp or complete)

Name: _____ Date: (MM/DD/YYYY) _____
Address: _____ Tel: _____
PRAC ID: _____ Fax: _____