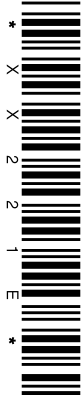


Alfred  Sandringham  Caulfield

## SPINE ASSESSMENT

for referrals to Neurosurgery New Spine Clinic, with initial Physiotherapy Assessment



Patient details		*mandatory fields			
Last name*		First name/s*			
Date of birth*		Sex at birth	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Other
Address					
Telephone		Email			
Medicare		Ref No			
Results / imaging is mandatory to accompany this assessment and referral: MRI preferred, CT is acceptable.					
Note: <b>Exclusion criteria</b> for our service: <ul style="list-style-type: none"> <li>- Treated for same condition at another Victorian public hospital</li> <li>- Degenerative spine pain only, and no presence of limb pain or neurological deficit (<b>unless significant instability on imaging, ie severe malalignment or dynamic instability (movement on flexion/extension imaging) that potentially carries a risk of spinal cord or cauda equina compression</b>)</li> <li>- Degenerative spine conditions where appropriate conservative strategies (<i>see below</i>) have not been optimised (in the absence of motor deficits)</li> <li>- Scoliosis (refer to Orthopaedic Clinic)</li> <li>- Under 18 years, unless previously treated at Alfred Health</li> <li>- Patients not wanting to consider surgery</li> </ul>					
Condition history					
Dominant symptoms	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic			
	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Limb (arm/leg) <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral			
Signs of neurological involvement		Details			
<b>Signs of upper motor neurone lesion</b> <i>Eg Spasticity, ankle clonus, ataxia, hyperreflexia, Hoffman's sign</i>	<input type="checkbox"/> Yes				
<b>Signs of cauda equina syndrome</b> <i>Eg saddle paraesthesia, incontinence, urinary retention. bilateral lower limb symptoms</i>	<input type="checkbox"/> Yes				
<b>Signs of lower motor neuron lesion</b> <i>Eg loss of sensation, weakness, asymmetrical reflex loss</i>	<input type="checkbox"/> Yes				
Have conservative treatment / management options been trialled, where appropriate?  <i>(Consider refreshers if of benefit and nil trialled within last 2 years)</i>	Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
	Physio / Chiro / Osteo	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
	Weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
	Pain programs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
	Other, acupuncture, myotherapy, etc. <i>list</i>				
Non-conservative treatment	Details	Efficacy (if known)			
Injection/s <i>Eg, nerve root or facet, level, side</i>		<input type="checkbox"/> Nil	<input type="checkbox"/> Short Term	<input type="checkbox"/> Sustained	
Date					
Spine surgery		<input type="checkbox"/> Nil	<input type="checkbox"/> Short Term	<input type="checkbox"/> Sustained	
Date					

Alfred  Sandringham  Caulfield

## SPINE ASSESSMENT

for referrals to Neurosurgery New Spine Clinic, with initial Physiotherapy Assessment

Last name*		First name/s*	
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Analgesia			
Current pain medication	<input type="checkbox"/> Paracetamol	<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Neuropathic
	<input type="checkbox"/> Other, <i>list</i>		
	Previous substance use <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medical history			
History or suspicion of cancer			<input type="checkbox"/> Yes
History of recent trauma / suspected fracture			<input type="checkbox"/> Yes
Cauda equina (sacral nerve root impairment)			<input type="checkbox"/> Yes
Saddle paraesthesia			<input type="checkbox"/> Yes
Incontinence			<input type="checkbox"/> Yes
Retention			<input type="checkbox"/> Yes
Bilateral LL symptoms			<input type="checkbox"/> Yes
Rapidly deteriorating neurology (including new onset foot drop)			<input type="checkbox"/> Yes
Signs and symptoms of infection			<input type="checkbox"/> Yes
Unexplained weight loss ( <i>greater than 5% over 4/52</i> )			<input type="checkbox"/> Yes
Night pain worse than day pain (severe, unrelenting)			<input type="checkbox"/> Yes
For Yes responses, provide details			
Investigations completed		Attach full report.	Image provider name & image date must be available
MRI		<input type="checkbox"/> Yes	
CT		<input type="checkbox"/> Yes	
Nuclear bone scan		<input type="checkbox"/> Yes	
X-ray		<input type="checkbox"/> Yes	
Ultrasound		<input type="checkbox"/> Yes	
Nerve Conduction Study		<input type="checkbox"/> Yes	
FBC / CRP / ESR / relevant biochemistry		<input type="checkbox"/> Yes	

Doctor completing this assessment			
Name		Address	
Telephone		Fax	
Provider No		Date	

Return completed Spine Assessment, referral and results, to Neurosurgery Spine Clinic

[op.referrals@alfred.org.au](mailto:op.referrals@alfred.org.au) T: 9076 2025 F: 9076 6938