SPINE REFERRAL INTAKE SHEET

Name: ____Birthdate:______________Age: _____________

Height_______________ Weight______________

REASON FOR REFERRAL: ____

REFERRING PROVIDER:____________________________CONTACT NUMBER:_____________________

ASSESSMENT

How was the spine problem discovered?____

____

Was this a sports injury? YES NO If so, what sport?____

Has this child started menstrual periods (if applicable?) YES NO When did they start? ____________

Does this child have any pertinent medical history? (i.e connective tissue disorder, syndrome, neurofibromatosis, prematurity, heart surgery, spine trauma, family history of scoliosis, etc)

____
____
____

Does this child experience back pain? YES NO Describe:____________________________________

____

Neurologic abnormalities on exam? YES NO Describe:_____________________________________

____

(i.e. foot deformity, bowel or bladder changes, radiculopathy, extremity weakness, sensory complaints, abnormal reflexes, cranial nerves)

IMAGING

Have x-rays been obtained? YES NO If yes, what are the results?_____________________________

____

Date of xrays______________ Other imaging results? (mri, ct, etc)______________________________

(XRAYS PREFERABLY DONE AT CHILDREN'S MERCY FACILITY, BUT MAY BE OBTAINED AT OUTSIDE FACILITY IF NECESSARY. PA AND LATERAL VIEWS OF THE UPRIGHT FULL SPINE INCLUDING PELVIS ARE RECOMMENDED FOR COMPLETENESS)

PLEASE FAX INTAKE SHEET TO (816)855-1776 ATTN ORTHO SCHEDULERS FOR REFERRAL.

RADIOLOGY REPORT STATING RESULTS OF IMAGING **MUST BE INCLUDED** WITH INTAKE SHEET IN ORDER TO FACILITATE TIMELINESS OF SCHEDULING.

REVISED 02/5/2014