RAC LBP RAPID ACCESS CLINICS FOR LOW BACK PAIN

CENTRAL WEST

FAX TO: 1-905-796-4912

Ontario

Patient Information

*Name:			OHIP#: VC#:
◯ Female ◯ Male	Age:	*Date of Birth: mm/dd/yyyy	*Daytime Phone#: ( )
*Address:			*City: *Postal Code:

Patient is eligible for for Rapid Access Clinic-Low Back Pain (RAC-LBP) referral if over 18 years of age with:
*Persistent LBP and/or related symptoms (e.g., sciatica, neurogenic claudication) that is not improving 6 wks. to 12 mos. from onset **OR** Unmanageable recurrent episodic LBP and/or related symptoms of <12 mos. duration post-recurrence.*

IMPORTANT: Patient is ineligible for RAC- LBP referral if one or more of the conditions apply:

- Patient with RED FLAGS
- Initial low back related symptoms <6 weeks post onset
- Constant/persistent LBP-related symptoms >12 months post onset
- <18 years of age
- Unmanaged established chronic multisite pain disorder
- Unmanaged established narcotic dependency
- Active LBP-related WSIB claim
- Active LBP-related motor vehicle accident claim
- Active LBP-related legal claim
- Pregnant/post-partum patients (<1 year)

Reason for referral: (check all that apply)

☐ Clarify diagnosis
☐ Recommend appropriate imaging
☐ Clarify need for specialist referral
☐ Recommend further treatment
☐ Clarify activity limitations / restrictions
☐ Other, please specify: _____

Back Specific History

1. Where has the pain / symptoms been the worst? (Check one)

◯ Back Dominant ◯ Leg Dominant

2. *Are emergent RED FLAGS present?

- **Possible Cauda Equina Syndrome:**
  - Loss of anal sphincter tone/ fecal incontinence
  - Saddle anaesthesia about anus, perineum, or genitals
  - Urinary retention with overflow incontinence
- **Progressive neurologic deficit**
- **Significant trauma**

◯ No
◯ Yes. **Please refer patient directly to the closest Emergency.**

3. *Is there a previous history of back problems?

◯ No ◯ Yes. Describe: _____

4. *Previous investigations, treatment or surgery for back problems?

◯ No ◯ Yes. Describe: _____

5. Relevant co-morbidities / Comments:

Does the patient have any YELLOW FLAGS?

☐ Belief that pain is harmful or severely disabling
☐ Fear avoidance behaviour (avoiding activity because of fear of pain)
☐ Low mood and social withdrawal
☐ Expectation that passive treatment rather than active treatment will help

Does the patient speak:
☐ English ☐ French ☐ Neither. If patient does not speak English, we recommend they bring a translator.

I hereby refer the above noted patient to RAC-LBP and a physician specialist as appropriate.

***Referring Practitioner Name:**	***Billing#:**	***CPSO#/CNO#:**
***Practitioner Address:**	***Fax#: ( )**	
Practitioner Signature:	***Date of Referral:** mm/dd/yyyy	