LHSC Spine Surgery Program

LHSC SPINE SURGEONS – Victoria Campus:

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Date of Referral: _____
(YYYY/MM/DD)

_____ _____ _____ _____
Patient (Last, First) DOB: (YYYY/MM/DD) AGE OHIP No.:

_____ _____ _____
Address Phone Number E-Mail Address

Location of Pathology:
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar/Sacral

DIAGNOSIS:
- ☐ Myelopathy
- ☐ Radiculopathy
- ☐ Neurogenic claudication
- ☐ Scoliosis (attach x-ray)
- ☐ Tumour
- ☐ Deformity
- ☐ Mechanical Pain
- ☐ Fractures*

HISTORY:

Is patient interested in surgery	☐	Yes	☐	No
Urgent	☐	Yes	☐	No
Current MRI included*	☐	Yes	☐	No

***All referrals require current MRI (within 1 year of referral) unless contraindicated or Primary diagnosis of Scoliosis**

Contact Information:

London Health Sciences Centre
800 Commissioners Road East
London, ON
Phone: 519-685-8500
General Fax: 519-933-4458
***For Fractures Fax To: 519-685-8447**

Referring Physician:

Name:
Billing No.:
Address:
Phone:
Fax:

OFFICE USE ONLY:

☐ Urgent ☐ Surgical ☐ MSK/RAC ☐ NON Surgical