Please Fax back to Dr Pope: (02) 9954 9307

the Mater

Dr R E Pope
Beneficence and Nonmaleficence
Neurosurgeon and Spine Surgeon

Spine Referral Form for GP's

Patient Information

Last Name: _____ First Name: _____
Medicare Number: _____ Health Fund Number: _____
Home Phone: _____ Mobile Number: _____
DOB: _ _/_ _/_ _

Referring Physician

Name:
Address: _____
_____
_____
Phone: (02) _____ Fax: (02) _____ Email: _____

Clinical Information

Spine Area: ☐ Cervical ☐ Thoracic ☐ Lumbo-Sacral

Symptom Duration: ☐ 0-6 wks ☐ 6-9 wks ☐ 3-9 mths ☐ 9-18 mths ☐ >18 mths

Points (0 or 1) **Clinical**		**Pathology**		**Radiology**	
Midline Pain Neck or Back	☐	Neoplastic Malignant	☐	Spondylolithesis	☐
Numbness Perianal and both legs	☐	Neoplastic Benign	☐	Cord signal/syrinx	☐
Neurogenic Claudication	☐	Infection	☐	Severe canal stenosis	☐
Pain/Numbness Arm or Leg	☐	Degenerative/Arthritic	☐	Root compression	☐
Focal Myotomal weakness Arm/Leg	☐	Congenital	☐	Mild/mod canal stenosis	☐
Myelopathy or Spasticity	☐	Low impact trauma	☐	Instability	☐
None of the above	☐	High impact trauma	☐	Foraminal stenosis	☐
Clinical Score Total	☐	**Pathology Score Total**	☐	Defomity	☐
Known previous referral: ☐ Yes ☐ No				Fracture	☐
TOTAL COMBINED SCORE ☐				Spinal cord compression	☐
				Radiology Score Total	☐

Referral Information

Date Received: __/__/____ Date Accepted: __/__/____
Recommendations: _____
_____
_____
_____

Date of Appointment with Dr Pope: __/__/____