UC IRVINE DEPT OF ORTHOPAEDIC SURGERY

URGENT SPINE SURGERY REFERRAL

PLEASE FAX TO: (714) 509-2168

INCLUDE ALL IMAGING STUDY REPORTS FROM THE PAST 12 MONTHS

Name:_____ DOB:_____

Chief Complaint:_____

How long have you had the symptoms:_____

Does the pain radiate to: Arm Leg Hand Fingers Foot Toes Right Left Both (please circle)

Do you have numbness: Arm Leg Hand Fingers Foot Toes Right Left Both (please circle)

Do you have weakness: Arm Leg Hand Fingers Foot Toes Right Left Both (please circle)

How severe is your pain on a scale of 1-10: _____ Constant Off/On Standing Walking Transitioning Bending Lying down Coughing / Sneezing Driving (please circle)

Where is the worst pain: Low Back Neck Legs Arms Hands (please circle)

What treatments have you had: PT Epidurals Facet- Blocks RFA SI injection (please circle)

How long did they help: _____

Have you had spine surgery? Date_____ Type of surgery: _____

Name of Surgeon:_____

Did surgery help? _____ For how long:_____

Medical History: _____

_____

Other Surgeries: _____

What spine imaging studies do you have? : MRI CT x-rays CT Myelogram (please circle)

Which spine surgeons would you prefer: (please circle)

Dr. Nitin Bhatia Dr. Yu-Po Lee Dr. Douglas Kiester Dr. Charles Rosen

PLEASE ATTACH IMAGING STUDY REPORTS AND ANY REPORTS FROM OTHER TREATING PHYSICANS.