Alberta Health Services

Pediatric Scoliosis Referral

Fax completed form to 587.521.9363

Patient Information

Last Name	First Name	Date of Birth *(yyyy-Mon-dd)*
Gender	PHN/ULI	Name of Parent(s) or Guardian(s) *(Last, First)*

Address	City/Town	Province	Postal Code
Home Phone Number	Work Phone Number	Cell Phone Number	
Name of Family Physician/Pediatrician	Prac ID	Phone Number	Fax Number

Referring Provider

Name *(print)* ☐ Same as above	Prac ID	Phone Number	Fax Number
Address	City/Town	Province	Postal Code

Signature

Referral Information

Diagnosis *(check all that apply)*

☐ Back Pain ☐ Kyphosis ☐ Lordosis
☐ Scoliosis ☐ Spondylolisthesis ☐ Trauma

Date of Menarche

Date Curve First Noticed	Noticed by *(name)*	Family History of Scoliosis ☐ Yes ☐ No

Pre-existing Medical Conditions

Previous treatment *(non-surgical/surgical)*

Investigations to Date	Degree of curvature on X-ray *(Cobb angle)*

Other concerns

To be Completed at Triage

☐ **Referral accepted**. A separate acknowledgement letter will be sent from the accepting provider's office.

☐ **Referral NOT accepted**. Based on the information provided and relevant imaging:

- ☐ Additional information on the patient is required. Please re-submit with:
  - ☐ Completed referral form
  - ☐ Consult letter
  - ☐ X-rays of _____
  - ☐ MRI _____
  - ☐ CT _____
  - ☐ Other _____
- ☐ Continue observation and repeat x-rays in 6 months' time. If curve magnitude is greater than 20 degrees, then consider re-referral.
- ☐ Given patient's age and curve magnitude less than 20 degrees, consultation is NOT warranted at this time. Should the patient's clinical history and/or imaging demonstrate significant worsening/pathology, consider re-referral.
- ☐ Imaging does not reveal a surgical lesion. Symptomatic treatment, including pain medications, physiotherapy, and aquacise suggested.