
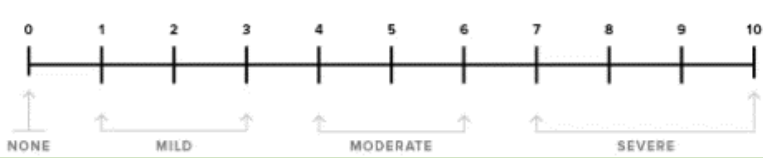




Patient Name _____ DOB ____ / ____ / ____
Patient Phone _____



- Diagnosis:** Chronic Low Back Pain (CLBP) +/- sciatica if mild and above knee
- Pain Related Disability:** Significantly impacts patient's daily activities
- Treatment History:** Tried medication & physical therapy
- Motivation:** Patient is open to further treatment
- Severe Pain:** NRS ≥ 6

- Radiculopathy:** Pain radiating below the knee, evidence of neuropathy, neurological deficits and/or pain in leg worse than lower back
- Comorbid Sacroiliac Joint Pain**
- Opioid Use:** [Oral daily equivalent](#) > 120mg morphine



- Comorbidity:** Patient is relatively healthy and comorbidity is not linked to CLBP
- Prior/Potential Lumbar Surgery/Procedures**
- Cancer History:** Consider need for future MRI

I am referring this patient to *The International Spine Centre's ReActiv8® Programme.*

Practitioner Name _____ Provider Number _____
Practitioner Signature _____ Date ____ / ____ / 20__

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