dist_logoWashington County School District Health Services

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| **SPINAL SCREENING**  **PARENT NOTIFICATION AND REFERRAL**  Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School School Nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dear Parent/Guardian:  Per parent request, your student received a spinal screening. Your child has signs of a possible curve listed below.  This does not mean your child has scoliosis. Only a physician can make that diagnosis. It is recommended that your child have a complete evaluation by your pediatrician or family physician. After the doctor has examined your child and completed this form, please return it to school. If you cannot afford a doctor or have questions, contact the school for information.  Thank you for your cooperation. Date : |

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| **School Screening Findings**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **L** | **R** |  | **L** | **R** |  | |  |  | Shoulder blade more prominent then other |  |  | High shoulder blade | |  |  | Obvious curve of the spine in upper back |  |  | Rib hump | |  |  | Obvious curve of the spine in lower back |  |  | High shoulder | |  |  | Obvious curve of the spine in area of rib cage |  |  | Hip higher than other side | |  |  | Waist to arm space greater |  |  | Other: |   **🞎** Waist creases uneven  **🞎** Rounded back  **🞎** Uneven on bend test by \_\_\_\_\_\_\_degrees  Trained School Staff\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (signature of trained personnel performing screening) |

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| **Physical Examination Report**  Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Recommendation:  🞎 No treatment  🞎 Observation only Follow up appointment scheduled(date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treatment:  Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Activity limitations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctor’s Signature/Stamp; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctor’s Mailing Address/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please fax results to: fax#: Thanks! |

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| For School Use:  Form completed and returned(name/date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Form not returned(reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Criteria for referral includes :

* Eight degrees or more on scoliometer or a combined reading (thoracic and lumbar) of 10 degrees or more
* Obvious curvature (kyphosis or lordosis)
* **Two or more** of the following:
* Shoulder or scapula asymmetry
* Space between arms body greater on one side
* One hip higher than the other
* Waist creases uneven