East Stroudsburg Area School District
East Stroudsburg, Pennsylvania 18301
Scoliosis Referral

Student's Name_____ Date_____

Dear Parent/Guardian:

In a recent screening program, your child displayed possible scoliosis or curvature of the spine. Further evaluation is recommended to determine if treatment is necessary. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated. It is recommended that your child have a complete evaluation by your family physician. Please have the examining physician complete the form below and return it to the school nurse.

By using the method depicted below, a possible spinal curvature was noted on this student.

Observations at Screening

1. Rib/Hump Lumbar Rotation
   ___Right Thoracic Rib Hump (RT)
   ___Left Thoracid Rib Hump (LT)
   ___Right Lumbar Rotation (RL)
   ___Left Lumbar Rotation (LL)

2. Other Orthopedic Conditions
   ___Pelvic Level
      ___Right iliac crest higher (HR)
      ___Left iliac crest higher (HL)
   ___Kyphosis (K)
   ___Lordosis (L)
   ___Other

_____
School Nurse

Address_____
_____
_____

PHYSICIAN'S FINDINGS

EXAMINATION (Please check)

1. Scoliosis confirmed
   *X-ray taken
   Degree of curve (specify) □
2. Possible Scoliosis
   No X-ray taken □
3. No Scoliosis
   X-ray taken □
4. No Scoliosis
   No X-ray taken □
5. Other orthopedic conditions
   confirmed □

*Single erect AP X-ray for baseline recommended by the American Academy of Orthopedic Surgeons.

RECOMMENDATIONS (Please check)

1. Will observe (O) □
2. Recommend bracing (B) □
3. Recommend surgery (S) □
4. Discharged (D) □

Comments_____
_____

Signature_____
Physician (Print)_____
Address_____
_____
Telephone_____
Date_____

East Stroudsburg Area School District
East Stroudsburg, Pennsylvania 18301

Private Physician's Scoliosis Screening

Student's Name_____ Sex_____ Grade_____ Date_____

PHYSICIAN'S FINDINGS

EXAMINATION (Please circle)

1. Scoliosis confirmed
   *X-ray taken
   Degree of curve (specify) _____
2. Possible Scoliosis
   No X-ray taken
3. No Scoliosis
   X-ray taken
4. No Scoliosis
   No X-ray taken
5. Other orthopedic conditions
   confirmed

RECOMMENDATIONS (Please circle)

1. Will observe
2. Recommend bracing
3. Recommend surgery
4. Discharged
5. Comments_____

_____

Signature_____

Physician (print)_____

Telephone_____

Date_____

*Single erect AP X-ray for baseline recommended by the American Academy of Orthopedic Surgeons.