

REFERRAL TO PHYSICIAN

Dear Parent of _____

School: _____

Date of Screening: _____

As required by Alabama state law, spinal screening is performed each year in grades 5, 6, 7, 8, and 9 (ages 11-14), including special education students. This screening does not replace your child's need for regular health care and check-ups by your physician.

With this letter, we are recommending that your child have a spinal exam **by a physician** with expertise in the treatment of spinal deformities.

You may call your child's school nurse to discuss these findings at _____.

Take this letter with you to your doctor's appointment. If you need assistance with an appointment or need a referral you may contact your private physician, the Tuscaloosa County Health Department at 562-6900, or the Children's Rehabilitation Services Scoliosis Clinic at 759-1279.

Sincerely,

Tuscaloosa County School Nurse

Report from physician. Please complete and return to school nurse.

DIAGNOSIS: _____ Scoliosis _____ Kyphosis
 _____ Other: Specify _____

TREATMENT: _____ None _____ Brace _____ Observation
 _____ Surgery _____ Other: Specify _____

FOLLOW-UP: _____

This information may be released to the school:

Name of physician _____ Office Number _____

Signature of physician _____ Date _____

Signature of parent or guardian _____ Date _____

This form should be addressed to: