

**TRINITY COUNTY OFFICE OF EDUCATION
SCOLIOSIS SCREENING REFERRAL AND REPORT**

Student Name: _____ Grade: _____ Date of Exam: _____

School: _____ School Nurse: _____

Dear Parent,

In a recent screening for Scoliosis (curvature of the spine) conducted at the school, indications are that the above named student appears to have some deviation from the normal as indicated below. Early diagnosis of the problem usually permits correction and prevents deformity. An examination by an orthopedic specialist or your family physician is recommended.

Please take this form with you at the time of the examination.

	1 Thoracic prominence(B)	R	L
	2 Extra folds --waist (A)	R	L
	3 Elevated scapula (A)	R	L
	4 Arm to body space greater (A)	R	L
	5 Shoulder higher (A)	R	L
	6 Spinous processes alignment (A)	R	L
	7 Iliac crest hip higher (A)	R	L
	8 Lumbar prominence (C)	R	L
	9 Prominent scapula (A)	R	L
	10 Lordosis (swayback)	Yes	No
	11 Kyphosis (D)	Yes	No

Examiner remarks: _____

Your signature below will authorize your child's physician to return the pertinent information to the school nurse. Thank you for your cooperation.

Parent's signature: _____ Date: _____

Dear Doctor:

The above named student was advised to seek further medical evaluation because our recent Scoliosis screening detected a curvature of the spine. If there is any follow up we can do in the school that would be beneficial to this student, would you kindly advise us.

PHYSICIAN'S REPORT TO THE SCHOOL

Comments: _____

Patient is being: Treated _____, Followed _____, Degree of curvature: _____

Physician's signature: _____ Date: _____

Address: _____ Phone: _____