Syracuse City School District
Health Services Department

725 Harrison Street
Syracuse, New York 13210

SCOLIOSIS SCREENING REFERRAL FORM

Name of student _____ Date of birth _____

School _____ Grade _____ Date _____

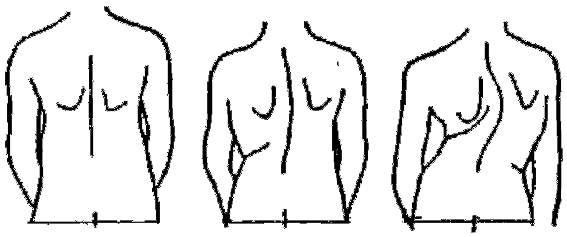
Dear Parents:

We recently completed a screening for spinal deformity at your child's school. The test indicated that your child may have a possible curvature of the spine. We urge you to contact your family physician or a pediatrician for further examination and advice.

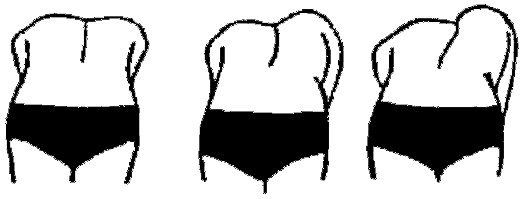
Because curvature of the spine often gets worse, we request you to have your child checked as soon as possible. When your child has been examined, please send us the doctor's report.

To give you a better picture of what we saw on looking at your child's back, please note the diagrams below. You may note a similar curve of your child's back.

View of Back Standing



View With Head Down



Slight Curve **Moderate Curve** **Severe Curve**

The diagrams above show a curve to the right

Your child's curve is to the _____ (R) _____ (L).

ATR (Angle of Trunk Rotation) _____.

Please take this referral form with you when you take your child to be seen by a physician. If you have any questions or need help in making an appointment, call the school nurse for assistance.

_____
School Nurse

_____
Phone Number