**MSK REFERRAL FORM**

PLEASE NOTE: Patients with symptoms of cauda equina compromise should go for acute orthopaedic admission agreed over the phone and NOT the Spine Service. This referral form EXCLUDES referrals for fracture clinic, urgent A&E referrals and suspected cancer 2WW



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Date** | | **Long date letter merged** | | | | | | | **NHS No** | | | **NHS Number** | | | | **BMI** | |  | | **Gender** | | **Gen der** |
| **Urgent referral** | |  | **If urgent please state reason** | | | | | | | | |  | | | | | | | | | | |
| **Patient Full Name** | | **Full Name** | | | | | | | | | | **DOB** | | **Date of Birth** | | **Referring GP Name** | | | | **Usual GP Full Name** | | |
| **Registered GP Practice** | | **Organisation Name Organisation Full Address (single line)** | | | | | | | | | | | | | | | | | | | | |
| **Patient Address** | | **Home Full Address (single line)** | | | | | | | | | | | | | | | | | | | | |
| **E-mail** | | **Patient E-mail Address** | | | | | | | | | | | | **Pref. Tel.** | | **Patient Home Telephone** | | | | | | |
| **Contact Number** | | **Patient Home Telephone / Patient Mobile Telephone** | | | | | | | | | | | | | | **Consent to leave message?** | | | | | |  |
| **Ambulance transport?** | |  | **Details** | | | | | | |  | | | | | | | | | | | | |
| **Occupation** | |  | | | | | | | | **Interpreter Required?** | | | | |  | **Which language?** | | | |  | | |
| **Patient OFF WORK due to condition?** | | | | |  |  | **If yes, how long for?** | | | | | | |  | | | | | | | | |
| **ANATOMICAL SITE: Knee** | | |  | **Hip** | | |  | **Hand&Wrist** | | | | |  | **Foot&Ankle** | |  | **Pain** | |  | **Spine** | |  |
| **Shoulder &Elbow** |  | **Rheumatology** | | | | |  | **If requesting DIRECT ACCESS PHYSIO please tick this box** | | | | | | | | | | | | | |  |
| **Please give a brief history and reason for referral (date of onset, comorbidities etc.)**  **Please note that PMH and medications will auto-populate from your clinical system into the bottom of this form.** | | | | | | | | | | | | **SYMPTOM DISTRIBUTION (Please mark on chart or drag and drop the symbols)**  **PAIN: NUMBNESS:**  **PINS & NEEDLES: SWELLING:** | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | |
| **Previous treatment: (Successful or not including physiotherapy, osteopathy etc.)** | | | | | | | | | | | | **Previous investigation: (Please attach reports)** | | | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | | | |
| **Any Red Flags? Please list in the blank box below:** | | | | | | | | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Please note that Red Flags include:** | | | | | | | | | | | **Immunosuppressed (other than steroids)** | | | | | | | **Hx of serious pathology** | | | | |
| **Unexplained weight loss (> 10% body weight in last 3-6/12)** | | | | | | | | | | | **Severe, unremitting night pain** | | | | | | | **Gait disturbance** | | | | |
| **Progressive weakness and/or sensory loss** | | | | | | | | | | | **Rapidly worsening neurological**  **symptoms** | | | | | | | **Hx of systemic illness** | | | | |
| **Additional details:** | | | | | | | | | | | | | | | | | | | | | | |

Medication

Medication

Medical History (Active Significant, Active Minor, Past Significant)

Problems

Allergies

Allergies

**PLEASE ATTACH ALL REQUIRED REPORTS, PREVIOUS CORRESPONDENCE AND ANY FURTHER INFORMATION REQUIRED**