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| Specialist Spasticity Management ServiceVitali ClinicDouglas Bader Rehabilitation CentreQueen Mary’s Hospital Roehampton  London SW15 5PN  Tel: 020 8487 6340  Email: stgh-tr.stgeorgesspasticityclinic@nhs.net |  |

## **Specialist Spasticity Management Service Referral Form**

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| **1. Patient Details** | |
| Full Name (forename, surname): | Date of Birth: |
| Address:  Postcode: | Contact Telephone Number: |
| NHS Number: |
| *If referral is for a child, please also supply parent / carer name below****:*** | |
| Full Name: | Relationship to Child: |
|  |  |
| **2. GP Details** | |
| Name: | |
| Address: | |
| Postcode: | |
|  | |
| **3. Hospital Consultant** | |
| Name and Hospital: | |

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| **Patient Name (forename, surname):** | **Date of Birth:** |

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| 1. **Details of Referrer** | |
| Name of Referrer: | Date Form Completed: |
| Position: | |
| Address: | |
| Telephone Number: | |
| Email Address: | |

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| 1. **Background Clinical Data of Patient** |
| Diagnosis: |
| Date of onset: |
| Current level of therapy input: |
| Past medical history: |
| Medication history (include any previous botulinum toxin): |
| Social history (including occupation, carers & leisure interests): |
| Cognitive status, e.g. motivation and would they participate actively in post botulinum toxin therapy: |

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| **Patient Name (forename, surname):** | **Date of Birth:** |

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| 1. **Details of Spasticity** | | | | | | | | | | |
| 1. **Impairment Location** | | | | | | | | | | |
| Right upper limb | | |  |  | Right lower limb | | | |  |  |
|  | | |  |  |  | | | |  |  |
| Left upper limb | | |  |  | Left lower limb | | | |  |  |
|  | | | | | | | | | | |
| 1. **Pattern of Spasticity** | | | | | | | | | | |
| Focal |  |  | Regional | |  |  | Generalised | |  |  |
| Details: | | | | | | | | | | |
| 1. **Is the Problem?** | | | | | | | | | | |
| Spasticity |  |  | Spasms | |  |  | Dystonia | |  |  |
| Other (please specify): | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. **Are there fixed contractures?** | | | | | | | | | | |
| Yes |  |  |  | | No | |  |  |  | |
| Details: | | | | | | | | | | |
| 1. **Walking Ability** | | | | | | | | | | |
| Independent |  |  | 1 or 2 sticks | |  |  | Frame | |  |  |
|  |  |  |  | |  |  |  | |  |  |
| Occasional Wheelchair |  |  | Wheelchair | |  |  | Dependent | |  |  |
|  |  |  |  |  |  |
| Details: | | | | | | | | | | |
| 1. **Level of Function** | | | | | | | | | | |
| Independent |  |  | Independent with assistance | |  |  | Dependent | |  |  |
|  |  |  |  |  |  |
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| Details: | | | | | | | | | | |

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| **Patient Name (forename, surname):** | **Date of Birth:** |

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| 1. **Reasons for Referral** |
| Patients problem(s) to be addressed:  1.  2.  3.  4. |
| Desired outcome of clinical intervention: |
| Any additional Information? |

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| **Patient Name (forename, surname):** | **Date of Birth:** |

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| 1. **Clinic Links** | | |
| Would you like your patient to be referred to any of the following services? If so, please give details why. | | |
|  |  | Drug management of spasticity |
|  |  |
|  |  | Botulinum toxin |
|  |  |
|  |  | Functional Electrical Stimulation |
|  |  |
|  |  | Gait Analysis (formal assessment of upper/lower limb function) |
|  |  |
|  |  | Splinting |
|  |  |
|  |  | Orthotics |
|  |  |
|  |  | Other |
|  |  |
|  | | |

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