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| Specialist Spasticity Management ServiceVitali ClinicDouglas Bader Rehabilitation CentreQueen Mary’s HospitalRoehamptonLondon SW15 5PNTel: 020 8487 6340Email: 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 |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| 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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