**MSK SINGLE POINT OF ACCESS REFERRAL FORM** (SGH website Feb 19)

All referrals **must** be sent to the “Wandsworth MSK Single Point of Access” on e-RS

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| **Inclusion criteria** | **ALL MSK SERVICES: Physiotherapy, Orthopaedics, Rheumatology, Pain, MICAS/MCAS,**  |
| **Exclusion criteria** | Suspected cancers; acute fractures; known / suspected cauda equina; systemically unwell; acute rheumatological conditions; neurological conditions or widespread neurology; lumps & bumps; non-MSK pain; non-MSK rehabilitation; domiciliary Physiotherapy. |
| **MSK Low Back Pain**  | **Please complete Start Back Tool for MSK Low Back Pain:****Total** **/9 Sub score** **/5** |

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| **IMPORTANT: PLEASE ADVISE YOUR PATIENT THAT, FOLLOWING CLINICAL TRIAGE OF THEIR REFERRAL, THEY WILL BE GIVEN AN APPOINTMENT FOR THE MOST APPROPRIATE MSK SERVICE TO MEET THEIR CLINICAL NEEDS.**  |

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| **Referring Clinician** |
| Referrer Name: |       | Date of referral: |       |
| Referring Organisation/Specialty: |       | Tel No: |       |
| Referrer Address, including email: |       | Fax No: |       |
| Postcode: |       |  |  |

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| **Patient Details** |
| Full Name: |       | NHS No: |       |
| Full Home Address: |       | DoB: |       |
| Gender: |       |
| Tel No (home): |       |
| Postcode: |       | Tel No (work): |       |
| Ethnic Origin: |       | Tel No (mobile): |       |
|  |  | Email address |       |
| If interpreter required, which language? |       |  |
| Is transport needed? Y [ ]  N [ ]   |  |
| **PATIENT CONSENT IS REQUIRED:** I confirm that the patient has consented to this referral:  |
| **PATIENT CHOICE:** Has the patient specifically requested referral to a non-local service? Y [ ]  N [ ]  If Yes, which Provider/Service has been requested:       |

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| **Reason for Referral: (please include duration or date of onset)** |
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| **Triage Information:** |
| Needs consideration for further investigation and / or Secondary Care [ ] Is the patient willing to consider surgery (if applicable)? Y [ ]  N [ ]   |
| **Diagnosis / Description of the Problem (please select if Yes)** |
| Is *this* problem significantly affecting the patient’s: | Work? | Y [ ]  N [ ]  N/A [ ]  |
| Daily function? | Y [ ]  N [ ]  |
| Sleep? | Y [ ]  N [ ]   |
| Neurological symptoms/signs? If yes, please give details: |       |
| Previous physiotherapy treatment for the same condition? **If Yes, please include details/ discharge report** | Y [ ]  N [ ]  |
| Has the patient had tests/imaging for this condition?**If Yes, please indicate below:** | Y [ ]  N [ ]  |
| X-Ray [ ]   | MRI [ ]  | CT [ ]  | Blood Tests [ ]   | USS [ ]  | **Please attach copies of test results or imaging**  |

**PLEASE ATTACH ANY RECENT AND RELEVANT CLINICAL HISTORY/INFORMATION TO AIDE REFERRAL TRIAGE AND SUBSEQUENT TREATMENT.**

HISTORY:

MEDICATION: