**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: