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**Richmond AQP Neck and Back Pain Referral Form**

For Richmond AQP patients wishing to be treated at Queen Mary’s Hospital, please send this completed referral form to   [waccg.physiotherapyoutpatients@nhs.net](mailto:waccg.physiotherapyoutpatients@nhs.net)

Queen Mary’s Hospital MSK Physiotherapy team are part of St George’s University Hospitals MSK Physiotherapy Service.

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT DETAILS** | | **PRACTICE DETAILS** | |
| Name |  | Date of Referral |  |
| DoB |  | Referring GP |  |
| Address |  | Practice Address |  |
| Telephone: Home |  | Telephone |  |
| Telephone: Mobile |  | Fax |  |
| Consent to leave message | Yes  No | E-mail |  |
| NHS Number |  |  |  |
| Gender |  | Interpreter Required | Yes  No |
| Ethnicity |  | Language |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please complete the following details fully to avoid delays in treatment:** | | | |
| Diagnosis |  | | |
| Duration | <6 weeks | 6-12 weeks | Other: |
| Previous treatments |  | | |
| Is the patient off work due to the problem? | Yes  No | | |
| Investigations | (please attach scan reports) | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **If Red Flag symptoms are present, please consider secondary referral:** | | | | | | | | |
| **Urgent Symptoms** | | | **Red Flags** | | | | | |
| Severe/poorly controlled pain | |  |  | Age <18 or >55 | |  | Malaise |  |
| Severe sleep disturbance | |  |  | History of cancer | |  | Steroid use |  |
| Condition likely to deteriorate quickly without action | |  |  | Non-mechanical pain | |  | Immunosuppression |  |
| Severe impairment of activities of daily living | |  |  | Thoracic pain | |  | Trauma |  |
| Deteriorating neurological states | |  |  | Unexplained weight loss | |  | Symptoms of Cauda equina |  |
| Relevant Medical History |  | | | | | | | |
| Current medication |  | | | | | | | |
| Other relevant information |  | | | | | | | |
| **STarT Back Score** | **/9** | | | | **Sub-Score** | | **/5** | |

**Please note: STarT Back score MUST be entered or referral will not be accepted (See StarT Back scoring sheet). Please ensure StarT Back Score completed for all referrals**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Disagree** | **Agree** |
|  |  | 0 | 1 |
| 1 | My back pain has **spread down my leg(s)** at some time in the last 2 weeks |  |  |
| 2 | I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks |  |  |
| 3 | I have only **walked short distances** because of my back pain |  |  |
| 4 | In the last 2 weeks, I have **dressed more slowly** than usual because of back pain |  |  |
| 5 | It’s not really safe for a person with a condition like mine to be physically active |  |  |
| 6 | **Worrying thoughts** have been going through my mind a lot of the time |  |  |
| 7 | I feel that **my back pain is terrible** and **it’s never going to get any better** |  |  |
| 8 | In general I have **not enjoyed** all the things I used to enjoy |  |  |

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | Slightly | Moderately | Very much | Extremely |
|  |  |  |  |  |
| 0 | 0 | 0 | 1 | 1 |

**Total score (all 9):** **Sub Score (Q5-9):**

# The STarT Back Tool Scoring System

Use STarT back score and sub score to stratify risk and aid management approach:

**Total score**

4 or more

3 or less

**Sub score Q5-9**

3 or less

4 or more

Low risk

Consider self management/analgesia

High risk

Consider physio referral

Consider CBT approach to management

Medium risk

Self management + consider physio referral

For low risk patients, please consider alternative treatments prior to referral