|  |  |
| --- | --- |
| **Date:** |  |
| **Patient Details:** |
| Name, Surname and Title |  |
| Gender | □ Female □ Male |
| NHS Number |  |
| Date of birth |  |
| Address and postcode |  |
| Telephone number |  |
| Mobile phone number |  |
| Where is the patient now? | □ At home □ In hospital |
| If the patient is in hospital please give hospital name, ward and direct dial ward phone number |  |

|  |
| --- |
| **Referring Organisation & Consultant**  |
| Name |  |
| Job title |  |
| Hospital, address and postcode |  |
| Direct dial phone number |  |
| Hospital email address |  |

|  |
| --- |
| **GP details:** |
| GP Name: |  |
| GP Practice Name: |  |
| GP Practice Address: |  |
| GP practice post code:  |  |

|  |
| --- |
| **Clinical information:** |
| **Reason for the referral** | □ MDT discussion only□ Transfer of care□ Inpatient transfer □ Second opinion   |
| **If the referral is for an MDT discussion, what question would you like us to answer?** |  |
| **History of the present problem** (if available, please provide date of operations and implants details if applicable for the relevant joint) |  |
| **Past Surgical History :** |  |
| **Past Medical History :** |  |
| **Are there any social, language or other holistic needs we should be aware of?** |  |

* Please transfer the relevant radiological investigations using Image Exchange Portal (IEP)
* Please ensure all sections of the proforma are **filled in and email** to: arthroplasty@stgeorges.nhs.uk

**If you have questions, please contact:**

 **Complex Arthroplasty Unit**

**Room 5015, 5th Floor, St James Wing**

**St George’s University Hospitals NHS Foundation Trust**

**Blackshaw Road, Tooting, London, SW17 0QT**

**Tel: 02087251689**