**INTERNAL MSK PHYSIOTHERAPY REFERRAL FORM**

Please email to Urgent Team CBS nmskoutpatientpathwayhub@stgeorges.nhs.uk

Appointment type to be booked into:

|  |  |  |
| --- | --- | --- |
| **Urgency** | **Urgent** [ ]  | **Routine** [ ]  |
| **TYPE:** | **Physio new 40** [ ]  | **Physio new 30** [ ]  | **Physio GP new**  [ ] Site: |
| **Walk-in** [ ]  |
| **SITE:** | **SGH** [ ]  | **SJTC** [ ]  | **QMH** [ ]  |

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| **Inclusion criteria** | **ALL MSK conditions for physiotherapy** |
| **Exclusion criteria** | Red flags; non-MSK pain; non-MSK rehabilitation; domiciliary Physiotherapy. |
| **MSK Low Back Pain**  | **Please complete Start Back Tool: Total**       **/9 Sub score**       **/5** |

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| **Reason for Referral: (please include duration or date of onset)** |
|  |
| **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**  |

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

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| **Patient Details** |
| Full Name: |   | MRN/NHS No: |   |
| Full Home Address: |   | DoB: |   |
| Gender: |   |
| Tel No : |  |
| Postcode: |   | Email address: |   |
| Ethnic Origin: |   | GP name: |   |
|  |  | GP 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: Y [ ]  N [ ]   |
| **PATIENT CHOICE:** Has the patient specifically requested to attend St Georges and not their local service Y [ ]  N [ ]   |

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

HISTORY:

MEDICATION: