**INTERNAL MSK PHYSIOTHERAPY REFERRAL FORM**

Please email to Urgent Team CBS [nmskoutpatientpathwayhub@stgeorges.nhs.uk](mailto: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: