**MSK SINGLE POINT OF ACCESS REFERRAL FORM**

**Please consider the use of the getUBetter app for self-management AND for self-referral to physio in the first instance. If you require any support, please email** [**contact@getubetter.com**](mailto:contact@getubetter.com)

**People not suitable for a digital first approach may be referred to the ‘Wandsworth Single Point of Access’ on eRS**

|  |  |
| --- | --- |
| **Inclusion criteria** | **ALL MSK SERVICES:**  **Physiotherapy, Orthopaedics, Neurosurgery, Rheumatology, Pain, MICAS, AQP Physio (Back & Neck)** |
| **Exclusion criteria** | Suspected red flags; acute rheumatological conditions; neurological conditions or widespread neurology; lumps & bumps; non-MSK pain; non-MSK rehabilitation; domiciliary physiotherapy. |
| **MSK Low Back Pain** | **Please use the getUbetter app for self-management and for self-referral to physio.**  **If not using getUBetter please complete Start Back Tool for MSK Low Back Pain:**  **Total** **/9 Sub score** **/5**  **Please ensure Startback tool is completed for all LBP patients to avoid rejection *(please refer to bottom of form)*** |

**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 OR MAY BE SUITABLE FOR SELF MANAGEMENT OPTIONS. PLEASE ENSURE 1 REFERRAL PER CONDITION**

|  |
| --- |
| **Reason for Referral: (please include duration or date of onset).** |
| Previous physiotherapy treatment for the same condition? Y  N  In last year? Y  N  **If Yes, did physiotherapy help** Y  N  **Please include details/discharge report** |
| **PLEASE ATTACH ANY RECENT AND RELEVANT CLINICAL HISTORY/INFORMATION TO AID REFERRAL TRIAGE AND SUBSEQUENT TREATMENT.** |
| Working Diagnosis:  History:  Medication: |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Further clinical details (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: | | | | | |  | |
| 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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| **Triage expectation - Please choose one only:** |
| Self-Management advice & education only  ***Please prescribe the getUBetter app***  Physiotherapy Urgent  Routine  **Urgent include:** Post fractures, Acute Traumatic Injury < 6 weeks, Post operative, Pre Op i.e ACL, WAD within 6 weeks, Consider whole clinical picture (Disturbed sleep/ off work / PMH / serious pathology / falls risk)  **Physiotherapy AQP –** Neck and Back only. Please discuss provider options but pleased note patients will be given this choice by BHCIC admin   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Ascenti |  | Healthshare |  | Ravenscroft Physiotherapy Centre |  | | St George’s NHS Trust – community |  | Surrey Physiotherapy |  | Vita Health Group |  | | AQP provider required but unknown | | |  |  | |   **MICAS Service -** Needs consideration for specialist MICAS opinion and further investigation/imaging  Needs consideration for Injection Therapy  **Secondary Care** - Direct referral to Secondary Care  Which service and rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **PATIENT CHOICE:** Has the patient specifically requested referral to a non-local service? Y  N  If Yes, which Provider/Service has been requested: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referring Clinician** | | | |
| Referrer Name: |  | Date of referral: |  |
| Referring |  | Tel No & Email |  |
| Organisation/Specialty: |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Details** | | | | |
| Full Name: |  | | NHS No: |  |
| Full Home Address: |  | | DoB: |  |
| Gender: |  |
| Tel No |  |
| Postcode: |  | |  |  |
| Ethnic Origin: |  | |  |  |
|  |  | | Email address |  |
| Is transport needed? Y  N | | Is an Interpreter required? Y  N  Language | | |
| **PATIENT CONSENT IS REQUIRED:**  I confirm that the patient has consented to this referral: Y  N  I confirm the patient has agreed to receive SMS appointment reminders and appropriate clinical information for self-management: Y  N | | | | |
| **Cognitive, Sensory or Mobility Impairment**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Sight Impaired (Blind) |  | Sight Impaired (Partially sighted) |  | Hearing Impaired (Deaf) |  | | Hearing Loss (Partial) |  | Speech Impaired |  | Learning Disability |  | | Autism |  | Mobility |  | Mental Health |  | | Dementia |  |  |  |  |  | | **Need related to:** Age, Religion/Belief, Sexual Orientation, Disability, Gender, Gender Reassignment, Race, Pregnancy and Maternity, Marriage and Civil Partnership | | | | |  | | Armed Forces |  | Other |  | None |  |   **IMPORTANT: Please describe relevant need to guide patient communication process**  Please include relevant details: | | | | |

**Start Back TOOL - Please ensure StarT Back Score completed for all LBP referrals to avoid rejection (N.B. If you prescribe getUBetter, the app will ask this for you)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **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 |
|  |  |  |  |  |

**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:

**Sub score Q5-9**

**4 or More**

**Total score**

**4 or More**

**3 or less**

**3 or less**

High Risk

Consider Physio referral

Consider CBT approach to Management

Medium Risk

Self management + consider physio referral

Low risk

Consider self management /analgesia