|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WiltshirE MSK OuPATIENT PHYSIOTHERAPY & ORTHOPAEDIC referral** | | | | | | | | | | | | | | |
| **Referral Form** | | | | | | | | | | | | | | |
| **By making this referral the patient agrees to receive text and email messages about their referral, appointments and management to the mobile phone number and email address listed below.** | | | | | | | | | | | | | | |
| **\***Referral Date: | |  | | | | | | | | | | | | |
| **\***Surname | |  | | | | Forenames | | | | |  | | | |
| Previous Surname | |  | | | | Title | |  | | | \*Sex | |  | |
| \*Date of Birth | |  | | | | \* NHS No | | | | |  | | | |
| \*Address | |  | | | | \*Daytime Tel No | | | | |  | | | |
| Mobile No | | | | |  | | | |
| Interpreter needed Language: | | | | | Yes  No | | | |
| Referring clinician – (contact details if available) | |  | | | | GP  Practice/Department  (Contact details if available) | | | | |  | | | |
| ANY CONDITION / ILLNESS THAT MAY AFFECT MENTAL CAPACITY TO CONSENT TO ASSESSMENT / TREATMENT? | | YES  NO  (PLEASE INCLUDE DETAILS BELOW) | | | | IS THE PATIENT AWARE OF THIS REFERRAL? | | | | | YES  NO | | | |
| IS THE PATIENT A CARER? | | | | | YES  NO | | | |
| ANY RELEVANT SAFEGUARDING INFORMATION? | | YES  NO  (PLEASE INCLUDE DETAILS BELOW) | | | | CHILDREN SAFEGUARDING  (0-18 years old)  IS THE CHILD/UNBORN CHILD, SUBJECT OF A CHILD PROTECTION PLAN?  IS THE CHILD LOOKED AFTER? (By Local Authority)  DOES THE CHILD HAVE A SOCIAL WORKER? | | | | | YES  NO  N/A  YES  NO  N/A  YES  NO  N/A | | | |
|  | |  | | | | FOR 14-25 YEAR OLDS, IS THIS REFERRAL PART OF TRANSITION PLANNING TO ADULT SERVICES? | | | | | | YES  NO | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | Military Service Person |  | Military Veteran |  | Member of Military Family | | | | | | | | | | | | | | | |
| **\*Referral Details** | | | | | | | | | | | | | | |
| **\*Has the patient received physiotherapy for this condition within the last 6 months**  **YES**  **NO**  **\*Please tick one of the following options.**  **Outpatient Physiotherapy (this includes classes for ESCAPE pain and Activate your back)**     **Orthopaedic Interface Service (OIS)**  (This option should be chosen if there has been no response to conservative management. Referrals will be triaged by Advanced Physiotherapy Practitioners using triage guidelines developed using NICE guidance, best practice guidelines and agreed by Orthopaedic lead consultants in our 3 acute partners. Referrals which require further investigations i.e. XRAY, MRI etc. or injections will be given an appointment in the OIS and may be referred back to outpatient services for further treatment. Those patients who have not responded to non-surgical options or meet the criteria for onward referral will be referred onto Orthopaedics). | | | | | | | | | | | | | | |
| \***Duration of symptoms** | | |  | | | **<6/52** | | | | **<12/52** | | | **>12/52** | |
| **For spinal pts –**  **main symptom** | | |  | | | **Back pain** | | | | **Leg pain** | | | **Neck pain** | **Arm pain** |
| **For peripheral pts** | | |  | **Locking** | | |  | | **Giving way** | | | | | |
| **\*Presenting problem and/or history of injury** | | | | | | | | | | | | | | |
| \*Diagnosis/reason for referral clearly described:  Knee  Shoulder  Hip  Spine  Hand  Other | | | | | | | | | | | | | | |
| **Patient unable to work due to current complaint** | Yes  No | | | | **Impact on daily activities or ability to work:** | | | | | Mild | | | Moderate | Severe |
| **Pain or distress** | Day | | | | Night | | | | | Mild | | | Moderate | Severe |
| **\***Please tick to confirm that none of the three features below are present: | | | | | | | | | | | | |  | |
| An Orthopaedic opinion is required if any of the following features are present:  1.       Reduced anal sphincter tone and/or faecal incontinence  2.       Urinary incontinence in context with the presenting issue or retention  3.       Reduced genital sensation  If the patient has had a recent onset, change or worsening of these symptoms, this could suggest acute Cauda Equina Syndrome and necessitates an **EMERGENCY referral by phone to the on call Orthopaedic Registrar.**  If symptoms are longstanding AND stable, please record this and complete a full neurological examination, including a PR, and attach to this eRS referral. We will direct on to Orthopaedics for their medical opinion. The patient should be given safety netting information so they are aware of what action to take if their symptoms worsen. | | | | | | | | | | | | | | |
| **Other History (or attach pertinent patient record/summary)** | | | | | | | | | | | | | | |
| Investigations | | |  | | | | | | | | | | | |
| \*Recent surgery  Please attach consultant instructions | | |  | | | | | | | | | | | |
| Medication | | |  | | | | | | | | | | | |
| Allergies | | |  | | | | | | | | | | | |
| Past medical history | | |  | | | | | | | | | | | |
| Additional Information | | |  | | | | | | | | | | | |

**Radiology:** (In last 6 months)

|  |  |  |
| --- | --- | --- |
| Location | Date | Summary of Findings |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Appropriate for referral to ISP Providers?** | **Yes** | **Provider specific** (Please provide more detail) | **No** |
| **Outcome** |  |  |  |

**ASA Classification – For Information Purposes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Onward Referral Information | | | | |
|  |  |  |  |  |
| Criteria | Y/N |  |  | Comments |
| **BMI** | BMI Under 40 | BMI 40-45 | BMI 45+ |  |
| **ASA Classification of 3 or above (see below)** | No | Yes |  |  |
| **BP** | <160/100 | 160/100-180/110 | >180/110 |  |
| **Other Factors (see below) such as comorbidities or other factors** | None | Other factors identified |  |  |

**Minimum Dataset:** (recordings in last 6months)

|  |  |  |  |
| --- | --- | --- | --- |
| **Blood Pressure** | 120 / 80 mmHg, 23 Aug 2013 | | |
| **Heart rate** | , | | |
| **Height** |  | **Smoking Status** | Ex-smoker, |
| **Weight** |  | **Alcohol Intake** | , |
| **BMI** |  | **Exercise tolerance:** |  |

Table

Description automatically generated with low confidence

**Other Relevant Factors to consider**

|  |  |
| --- | --- |
| Pregnancy | Not suitable for ISP |
| Substance Misuse | Dependent on history and provider |
| Anaesthesia history | Dependent on history and provider |
| Known history of anaphylaxis | Dependent on history and provider |
| Mental Health | Dependent on history and provider |
| Obstructive Sleep Apnoea | Dependent on history and provider |
| Haematological Disorders, including current anticoagulation | Dependent on history and provider |

**Please ensure that all fields demoted by \* are completed correctly**

**INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED TO THE REFERRER**