|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral for ():**  **MSK Referral Form**  This service only accepts referrals via Choose and Book, any referrals received by alternative methods may be rejected. This service can be found  by searching for Musculoskeletal Service. | **MSK** |  | **Physio** |  | **Podiatry** |  | *Tick one option only* |
|  | |  | | | | | |
| Date of referral: | |  | | | | | |
| Referring GP: | |  | | | | | |
| Practice Name and Address: | |  | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Name: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| NHS Number: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Address and postcode: | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Contact telephone numbers: | | | | | | Home | | | | | | | Mobile | | | | | | Work | | | | | Other | | |
|  | | | | | | |  | | | | | |  | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent for text message reminder () | | | | | | | | |  | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Routine referral () | | |  | | Urgent referral () | | | | | | | | | | |  |  | | | | | | | | | |
| **Criteria for urgent: Possible ligament or meniscal injury to knee / Severe pain and reduced function of joint**  **Acute ligament injury to ankle or shoulder** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Body Area** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please note: Each problem will require separate UBRNs on Choose and Book. Use a separate form if referring multiple problems.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Upper Limb** () | | | | | | | | | | | | | | **Lower Limb** () | | | | | | | | | | | | |
| Shoulder | | Left | | | |  | Right | | |  | | | | Hip/Groin | | | | | | | Left | |  | | Right |  |
| Elbow | | Left | | | |  | Right | | |  | | | | Knee | | | | | | | Left | |  | | Right |  |
| Wrist | | Left | | | |  | Right | | |  | | | | Ankle | | | | | | | Left | |  | | Right |  |
| Hand | | Left | | | |  | Right | | |  | | | | Foot | | | | | | | Left | |  | | Right |  |
| Other (Specify) | | | | | | | | | | | | | | Other (Specify) | | | | | | | | | | | | |
| **Previous Treatments – Please include date of treatment** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physiotherapy | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Injection | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Podiatry | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Surgery (please provide further information) | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Other (please specify) | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| **Previous Investigations – Please include date and results if known** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MRI | | | |  | | | | | | | | | | Ultrasound | | | | | | | |  | | | | |
| X-Ray | | | |  | | | | | | | | | | Bloods | | | | | | | |  | | | | |
| Other (please specify) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Brief History and Background** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Past Medical History** | | | | | | | | | | | | | | | **Medication** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Preferred Location () | Basingstoke | | | | | | |  | | | Alton | | | | | | |  | |  | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | |