|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Southern Health NHS Foundation Trust  Lymington New Forest Hospital  Wellworthy Road  Hants SO41 8QD  Tel: 0300 003 0806 Age 16 + service only | | | **REFERRAL FORM**  **SPINAL**  **WHCCG** | | |  | |
| Urgent  Non-Urgent Lumbar  Cervical  Thoracic **Direct consultant opinion required**  Orthopaedic Choice are unable to accept patients with (1) suspected **cauda equina** syndrome, please refer to A&E immediately or (2) suspected **malignant disease,** please refer to 2 week-wait or oncology or contact radiology directly for urgent imaging. | | | | |
| Forename: **«PATIENT\_Forename1»**  Surname: **«PATIENT\_Surname»**  Address: **«PATIENT\_BlockAddress»**  Patient consent to leave a message?  Home No: «PATIENT\_Main\_Comm\_No»  Work No: «PATIENT\_Alt\_Comm\_No»  Mobile No: «PATIENT\_Mobile\_No»  When is the best time to call?    Email:  The service strives to contact patients as quickly as possible. Please help us by providing as many contact details as possible. | | | Sex: **«PATIENT\_Sex»**  DoB: **«PATIENT\_Date\_of\_Birth»**  NHS no: **«PATIENT\_Current\_NHS\_Number»**  UBRN No: «REFERRAL\_UBRN»  Hospital No: «REFERRAL\_Hospital\_number»  Previous Name: «PATIENT\_Previous\_Surname»  Occupation: | | | | Registered GP: **«PATIENT\_Registered\_GP»**  Referring GP: **«REFERRAL\_Clinician»**  Surgery address: **«PRACTICE\_BlockAddress»**  E-mail:  Phone: «PRACTICE\_Main\_Comm\_No»  Fax: «PRACTICE\_Fax\_No»  Date of Referral: «SYSTEM\_Date» |
| **CURRENT EPISODE OF SPINAL PAIN:**  Acute 1st episode: Yes  No  Acute exacerbation chronic condition:  Details of onset: Spontaneous:  Following minor back strain:  Following major injury:  Duration of current symptoms: <6/52  6/52 - 3/12  3/12 - 6/12  >6/12  Is the patient off work due to back pain? Yes  No  If yes, for how long?  Is the patient unable to sleep due to back pain? Yes  No | | | | | | | |
| **Current BMI** (latest): «PATIENT\_BMI» (if reading not in last 6 months, please retake): | | | | | | | |
| **Red flags**:  e.g. Age <20 / >55  Thoracic pain  Steroids  Cancer  Weight loss  Psychosocial factors:  Yes  No  Psychiatric history:  Yes  No | **Neurological signs:** | Yes | | No | Where | | |
| Motor loss |  | |  |  | | |
| Sensory loss |  | |  |  | | |
| Reflex changes |  | |  |  | | |
| Upper Motor Neurone signs |  | |  |  | | |
| Leg or arm symptoms |  | |  |  | | |
| Positive straight leg raise |  | |  |  | | |
| **PREVIOUS TREATMENT FOR BACK PAIN (with dates):**  Physiotherapy:    Surgical:    Rheumatology:    Pain Clinic: | **DESCRIPTION OF CURRENT EPISODE:**    **CURRENT TREATMENT OF BACK PAIN (including medication):** | | | | | | |

|  |
| --- |
| **TEST RESULTS: (please attach)**  X-rays/Scans: What:  Where:  Blood tests  **Full Blood Count**    **Erythrocyte sedimentation rate**    **Plasma C Reactive Protein**    **Prostate Specific Antigen**    Other blood tests: |
| Previous relevant orthopaedic referrals: Yes  No  Where:       Why: |
| Expectation of referral (GP and Patient): |
| Additional info, e.g. Practitioner safety, specific needs etc…: |

Summary of Patient’s Record:

**Family History**

**Problems**

**«PROBLEMS»**

**Medication**

**«REPEATS»**

**Allergies**

**«DRUG\_ALLERGY»**