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| Southern Health NHS Foundation TrustLymington New Forest HospitalWellworthy RoadHants SO41 8QDTel: 0300 003 0806Age 16 + service only | **REFERRAL FORM****UPPER LIMB** |  |
| [ ] Urgent [ ]  Non-Urgent[ ]  Shoulder [ ]  Elbow [ ]  Wrist/hand **[ ]  DIRECT CONSULTANT OPINION REQUESTED** |
| 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» |
| **MINIMUM CLINICAL DATA SET: THE FIELDS MARKED \* BELOW MUST BE COMPLETED FOR REFERRAL TO BE ACCEPTED. BMI IS ESSENTIAL FOR ALL REFERRALS** |
| Signs/Symptoms: **MUST INCLUDE \*DURATION, \*SEVERITY, \*SITE of problem and \*LATERALITY**     **\***EFFECT ON FUNCTION (use of arm/hand etc):      **\***EFFECT ON SLEEP:      **\***ANY OCCUPATIONAL FACTORS:      Provisional diagnosis:       |
| **\*Current BMI** ( latest): «PATIENT\_BMI» (if reading not in last 6 months, please retake):       |
| **\***Previous relevant orthopaedic referrals: Yes [ ]  No [ ]  Where:       Why:       |
| **\***Previous treatment for lower limb **pain (include dates and details)**Physiotherapy: [ ] Injections: [ ] Surgical: [ ] Pain clinic: [ ] Podiatry: [ ]  | **\***Current treatment for lower limb pain **(including current medication)**      |
| **\*Test Results: (please attach)**X ray/scans: what:      Where:      **Blood tests: (if relevant)**  |
| Expectation of referral (GP and Patient) including surgical expectations etc:       |
| Additional info, e.g. Practitioner safety, specific needs etc…:        |

Summary of Patient’s Record:

**Family History (if relevant)**

**\*Relevant PMH**

**«PROBLEMS»**

**\*Repeat Medication**

**«REPEATS»**

**Allergies**

**«DRUG\_ALLERGY»**