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| Southern Health NHS Foundation Trust  Lymington New Forest Hospital  Wellworthy Road  Hants SO41 8QD  Tel: 0300 003 0806  Age 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»**