**Orthopaedic Choice Specialist Referral Form**

**Please do not refer to Orthopaedic choice if you suspect:**

* **Possible Cauda Equina Syndrome** this warrants emergency action please ref to UHS via on call spinal registrar.
* **Cancer,** please refer via 2WW pathway
* **Fracture** or an **acute locked knee** refer via local orthopaedic department or emergency department.
* For spinal fracture please consider x-ray, pain management, myeloma screen and or Dexa scan and refer to rheumatology initially

**Please consider using our Advice and Guidance service via ERS if you want to clarify any questions/advice**

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| Contact Details for the services | | | | | | | | | | | | | | |
| Email | | outpatients@southernhealth.nhs.uk | | | | | | | | | | | | |
| Telephone | | 0300 003 0806 | | | | | | | | | | | | |
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| Section 1 - Patient’s details | | | | | | | Patient’s background and culture | | | | | | | |
| Name | Full Name | | | | | | Ethnicity | | Ethnic Origin | | | | | |
|  |  | | | | | | 1st language | | Main Language | | | | | |
| DOB | Date of Birth | | | Age | Age | | Interpreter required? Interpreter required | | | | | | | |
| Sex | Gender(full) | | | | | | Military Veteran? | | | | | | | |
| Address & postcode | Home Full Address (stacked) | | | | | | Patient BMI: | | | Date Recorded | | |  | |
|  |  | | | | | | Section 2 - Referrer details | | | | | | | |
|  |  | | | | | | Referring Clinician | |  | | | | | |
|  |  | | | | | | Address | | Organisation Name  Organisation Full Address (stacked) | | | | | |
| NHS No | NHS Number | | | | | | Tel no | | Organisation Telephone Number | | | | | |
| Hospital No | Hospital Number | | | | | | Email | | Organisation E-mail Address | | | | | |
| Home tel | Patient Home Telephone | | | | | | Referral date | | Short date letter merged | | | | | |
| Work tel | Patient Work Telephone | | | | | |  | |  | | | | | |
| Mobile tel | Patient Mobile Telephone | | | | | |  | |  | | | | | |
| Email | Patient E-mail Address | | | | | |  | |  | | | | | |
| Preferred contact method | | | Home | | |  | Work |  | Mobile | |  | E-mail | |  |

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| **Social Information** | | | | |
| Social Context | Transport Issues | Has a Carer | Is a Carer | Lives Alone |
| Next of Kin |  | | | |
| Relationship to Patient |  | | Telephone No |  |

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| **Section 3 - Body Part and Grade** | | | | | | | | | | | | | | | |
| **A**rea of pain / problem | **L**umbar | |  | | **C**ervical |  | | **T**horacic |  | | | **H**ip |  | Foot & Ankle |  |
| **S**houlder | |  | | **E**lbow |  | | **H**and | |  | | **K**nee |  |  | |
| **Spinal Urgent Criteria**   * Rapidly deteriorating neurology which has not improved within a reasonable timeframe – please complete assessment findings below   **Peripheral Urgent Criteria**   * Recent trauma/recent onset of severe and/or worsening pain and or function having failed simple management measures | | | | | | | | | | | | | | | |
| **\*Advice** | | **Routine** | | | | | **Urgent** | | | | **Direct consultant referral**  **\*See section 10** | | | | |
| **Section 4 Referrer question and previous treatment** | | | | | | | | | | | | | | | |
| What is your clinical question and reason for referral to Orthopaedic Choice? | | | | | | | | | | | | | | | |
| Has conservative management been tried for ***this*** episode? (e.g., Physiotherapy, Steroid injection, splinting and escalation up the analgesic ladder). | | | | | | | | | | | | | | | |
| Referral to weight management? | | | | | | | | | | | | | | | |
| **Section 5 – History of Symptoms and Presenting Symptoms** | | | | | | | | | | | | | | | |
| History of present condition: (onset, duration, episode, previous surgery date and location) | | | | | | | | | | | | | | | |
| Present symptoms and location of pain: (Please add laterality and objective findings)  Including: effect on sleep and function | | | | | | | | | | | | | | | |
| **Section 6 – Previous Investigation’s**  Please order Xray before or at time of referral if suspect OA/ peripheral weight bearing joint >50yrs/stiff and painful shoulder. | | | | | | | | | | | | | | | |
| Investigation type:  Hospital Name:  Date: | | | | Comments:  Report:  Please attach blood tests results if relevant: | | | | | | | | | | | |
| **Section 7 – Neurological Examination grade out of 5 on the Oxford Scale**  **(Mandatory for Spinal Referrals)** | | | | | | | | | | | | | | | |
| **Power upper / lower limb:** | | |  | | | | | | | | | | | | |
| **Reflexes:** | | |  | | | | | | | | | | | | |
| **Sensation:** | | |  | | | | | | | | | | | | |
| **Upper motor signs / Gait / coordination:** | | |  | | | | | | | | | | | | |
| **Section 8 – Past Medical History -** please attach summary | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Section 9 – Medication –** please attach summary | | | | | | | | | | | | | | | |
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| **Section 10 – Prior Approval** | | | | | | | | | | | | | | | |
| **For referrals to secondary care please consider if the prior approval criteria have been fulfilled.**  [*Policies and Funding Information for Hampshire, Southampton & Isle of Wight - South, Central and West (cscsu.nhs.uk)*](https://gbr01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.fundingrequests.cscsu.nhs.uk%2Fclinical-commissioning-groups-hampshire%2Fpolicies-guidance-ccgs-hampshire%2F&data=04%7C01%7CKomal.Bhuchhada%40southernhealth.nhs.uk%7C40f4458df1d648ec097d08d9e1b5ab94%7C4e6404cac8c142369c2c22845a98a473%7C0%7C0%7C637788992639169442%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=1ml8mHVlawk%2BoYyBxiJNEV%2BHHgEHFgQHrgumhrWmpuk%3D&reserved=0)  ***Please note the following:***   1. Patient with BMI above 35 seeking joint replacement surgery require referral to tier II/III weight management and prior approval completing. 2. Non traumatic meniscal tears without locking are not eligible for arthroscopic surgery and are subject to prior approval. 3. Shoulder subacromial decompression surgery is subject to prior approval and requires course of physiotherapy to be completed and a CSI to produce short term benefit to be considered. 4. Ganglion excision is not routinely funded, and prior approval is always required. | | | | | | | | | | | | | | | |
| Please state the procedure you are requesting and attach the relevant completed prior approval documentation if appropriate to do so. | | | | | | |  | | | | | | | | |