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| **Referral Criteria:**   * **Patients must have a neurological diagnosis as primary presenting complaint** * **Patient must be aged 18 years of age or over** * **Spasticity is having a clear negative impact on the patient** * **There must be a clear treatment goal identified by the patient / referrer** |

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| 1. **Patient Details** | |
| Full Name (Forename, Surname): | Date of Birth: |
| Address:  Postcode: | Contact Telephone Number: |
| NHS Number: |

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| 1. **GP Details** |
| GP Name: |
| GP Surgery: |
| GP Address: |

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| 1. **Details of Referrer** | |
| Name of Referrer: | Date Form Completed: |
| Profession: | |
| Address for Correspondence: | |
| Contact Email: | |
| Contact Telephone: | |

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| **4. Background Clinical Data of Patient** |
| Diagnosis: |
| Date of onset: |
| Current level of therapy input: |
| Past medical history: |
| Medication history (include any previous botulinum toxin):  Is the patient on anticoagulant medication? Yes/No |
| Social history (including need for care/support, occupation, leisure interests): |
| Cognitive status and any communication issues? |

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| **5. Details of Spasticity** |
| 1. **Impairment Location**   Right upper limb  Right lower limb  Left upper limb  Left lower limb  Other (please provide details): |
| 1. **Pattern of Spasticity**   Focal (1-2joints)  Global ( affecting more than 2 joints/1 limb)  **Details:** |
| 1. **Are there fixed contractures?**   Yes  No  Details: |
| 1. **Walking Ability**   Independent  1 or 2 sticks  Frame  Occasional Wheelchair Wheelchair  Dependent  Details: |
| 1. **Level of Function**   Independent  Independent with assistance  Dependent  Details: |

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| **6. Reasons for Referral** |
| Please provide information regarding the impact of spasticity on day to day life (tick main concerns and give details below)  Pain  Function  Difficulty achieving seating  Skin integrity  Body image  Personal care  Orthotic/splint fit  Please give details: |
| Please provide information about any strategies that have already been used to help manage patient’s spasticity: |
| Please indicate treatment goals that you/your patient hope to achieve by referral to Solent Spasticity services: |
| Any additional Information? |

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| **7. Clinics** |
| Which service would you prefer your patient to be seen in?    Medical Clinic, for review of muscle relaxant medication  Multidisciplinary clinic for full holistic assessment of spasticity  Botulinum toxin clinic, for treatment of focal spasticity  Intrathecal Baclofen Assessment |

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| **8. Transportation needs** |
| How do they travel to clinic?  Own Transport  Require Hospital Transport  Require Home Visit – please note home visits can only be carried out in exceptional  circumstances. Botulinum is not administered in the community. |

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| **If Using SystmOne:** Please send this form via electronic referral, selecting the followingtask recipient  **2 CNRT eReferral Southampton** |
| **If Not Using SystmOne:** Please send this form to  [**SNHS.CNRT@nhs.net**](mailto:SNHS.CNRT@nhs.net) |
| **For further advice, please contact us on**: Tel No: 0300 123 5007 Option 3  Spasticity Services  Western Community Hospital, William Macleod Way, Millbrook, Southampton SO16 4XE |