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| **Berkshire West AQP MSK Physiotherapy Service – Referral Form** | | | | | |
| **Section One** | | | | | |
| **Important – Please Read**  The data entered into Section One of this form is read automatically.  **Please do not make any changes to the layout or wording in Section One as this may result in the form being rejected.** | | | | | |
| **Date** |  | | | | |
| **Patient Details** | | | | | |
| **Name:** |  | | | | |
| **NHS Number:** |  | | | | |
| **Date of Birth:** |  | | | | |
| **Gender:** |  | | | | |
| **Ethnicity:** |  | | | | |
| **Address:** |  | | | | |
| **Landline Tel:** |  | | | | |
| **Mobile Tel:** |  | | **Happy to Receive Text Messages:** | Yes  No | |
| **Work Tel:** |  | | | | |
| **Email:** |  | | | | |
| **Referrer Details** | | | | | |
| **Name:** |  | | | | |
| **Practice Code:** |  | | | | |
| **Communication and Assistance END *Please mark the box with X where applicable*** | | | | | **Yes** |
| **Does the patient require an interpreter?** | | | | |  |
| **Is the patient suitable for a telephone assessment? *If not, please provide details in Comments below*** | | | | |  |
| **Patient Language:** | |  | | | |
| **Comments:** | |  | | | |
| **Reason for Referral** | | | | | |
|  | | | | | |
| **YOU MUST COMPLETE THESE QUESTIONS TO FACILITATE PRIORITISATION** | | | | | |

|  |  |
| --- | --- |
| **Onset**  **<1 Week**  **1-4 Weeks**  **5-12 Weeks**  **>12 Weeks** | **Severity of Symptoms:**  **Mild**  **Moderate**  **Severe**  **Unable to work** |
| **Recent Trauma**  **YES**  **NO** | **Post-Operation?**  **YES**  **NO** |
| **Weight Bearing?**  **Full**  **None**  **Part** | **Sleep Disturbances?**  **YES**  **NO** |

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| **Berkshire West AQP MSK Physiotherapy Service – Referral Form** |
| **Section Two** |
| **Important – Please Read** Please provide as much information as possible – a failure to do this may lead to an inability to triage the patient effectively and the referral being rejected. |
| **Clinical History and Examination Findings** |
|  |
| **Details and Dates of Previous Treatment Related to this Condition** |
|  |
| **Current Consultation** |
|  |
| **Allergies and Sensitivities** |
|  |
| **Medications** |
|  |
| **Recent Diagnostic Tests** |
|  |
| **Please hand the MSK Information card to your patient before they leave** |

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| **Berkshire West AQP MSK Physiotherapy Service – Referral Form** |
| **Guidance** |
| **This referral form must be completed in full and attached to the ERS booking.**  **Please print out the patient leaflet and give it to your patient before they leave.**  [**Return to Section One**](#ServiceRequested) |