Practice Plus Group MSK, Buckinghamshire

Please attach this referral form to the e-RS UBRN

IF MANUAL VERSION USED DO NOT HAND WRITE – MUST BE TYPED

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Details | | Tel (Daytime): | ~[Telephone Number] |
| Name: | ~[Title] ~[Forename] ~[Surname] | Tel (Work): |  |
| Date of Birth: | ~[Date Of Birth] | Tel (Mobile): | ~[Mobile] |
| Gender: | ~[Sex] | Email Address: | ~[Email 1] |
| NHS No: | ~[NHS Number] | First Language: |  |
| Address: | ~[Patient Address Line 1]  ~[Patient Address Line 2]  ~[Patient Address Line 3]  ~[Patient Address Line 4]  ~[Post Code] | Ethnicity: | ~[Ethnicity] |
|  |  | Interpreter Required | Yes  No |
|  |  | Transport Required | Yes  No |
|  |  | Urgent |  |
|  |  |  |  |
| GP Details: | | GP Telephone Number | Just type in number |  |
| GP Name: | ~[Usual Doctor] | GP Fax Number | Just type in number |
| Address: | Just Type in address before saving and protecting | GP Email | Just type in email |
|  |  | Date of referral |  |

Please complete the following sections as appropriate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **History, Symptoms & Clinical Findings. Please include reason for referral & (provisional) diagnosis.** | | | | | |
| **Area(s) affected:** | | **Duration:**  How long have the patient’s symptoms been present?  \*\*please ensure symptom duration warrants referral in line with GP pathways\*\* | | **This patient:**  Is unable to work  Is struggling at work  Is not coping  Is having significant sleep problems  Is unable to care for dependents | |
|  | **Women’s Health**  (Please Tick) |
| **Presenting Problem:** ***Please include all detail possible.*** *(Box will get bigger as you type)* | | | | | |
| **Past Medical History:** | | | | | |
| **Has early management been provided in line with GP pathways** e.g. analgesics, exercise leaflet given, activity modification advice, weight management advice, X-ray, footwear advice, walking aids etc.    **Yes,** please provide details  **No,** please explain reason for early referral | | | | | |
| **Keele STarT Back Screening Score (Spinal or Musculoskeletal)**  Total Score (all 9 questions)       Sub Score (Q5 -9)  [**https://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele\_STarT\_Back9\_item-7.pdf**](https://www.keele.ac.uk/media/keeleuniversity/group/startback/Keele_STarT_Back9_item-7.pdf) | | | | | Scans have been done  If so, where  **Type and Outcome:** |
| **I expect this patient to be treated by:**  Therapist  MSK Service  Secondary Care (onward referral) | | | ***If Secondary care please complete the following****:*  Patient consented to surgery  Patient fit for surgery  BMI  Weight loss programme tried | | |
| \*\*Please provide as much information as possible to support your request and please inform your patient that all referrals are triaged according to the locally agreed pathways of care, so they may not be seen by the clinician you have requested in all cases | | | | | |
| **Allergies/adverse drug reactions**: ~[Allergies] | | | | | |
| **Current Medication**: ~[Medication] | | | | | |
| **Onward Referral:** *Please ensure that this section is completed so that your patient’s choices can be applied.* | | | | | |
| This patient has chosen the following hospitals, should onward referral be required: | | | | | |