E-REFERRAL BARNSLEY MUSCULOSKELETAL SERVICE

Patient referrals must be completed with ALL required information. In line with CCG requirements, incomplete referrals will be rejected and returned to the referrer for review or clarification. This may cause a delay in management.

Name: <Patient Name> **Address:** <Patient Address> **Date of Birth:** <Date of Birth> **NHS Number:** <NHS number> **Tel:** <Patient Contact Details> **Mobile:** <Patient Contact Details> **Gender:** <Gender> **Ethnicity:** <Ethnicity> **Main Language:** <Main spoken language> **Interpreter Required?** ☐Yes ☐No	**Registered GP:** <GP Name> **Address:** <Organisation Address> **Tel:** <Organisation Details> **Practice Code:** <Organisation Details> **Referring Clinician:** <Sender Name> **Date:** <Today's date>

Referring to

▶ Musculoskeletal (including Physiotherapy) ☐

Orthopaedics * see investigations ☐ Rheumatology ☐ Pain Management ☐

Appointment urgency

☐ Routine ☐ Urgent

Reason for Referral

▶ <Insert reason for referral as descriptive text. Nature of problem, duration and potential related symptoms>

Management for this problem so far?

Expectations of referral:

▶<Insert Expectation from referral would be helpful and perception of main problem>

☐ No Red Flags

☐ **Red Flags – Patients requiring treatment for Red Flags should be referred on the appropriate acute pathway**

☐ History of Ca ☐ Significant unexplained weight loss

☐ Night Pain ☐ Related sleep disturbance

☐ Cauda Equina symptoms

☐ **Metastasis ruled out – where there is a previous history of cancer please confirm that metastasis has been ruled out before referral**

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Patient Name: <Patient Name>
NHS Number: <NHS number>

Investigations: (X-Ray, USS, MRI, Bloods, including those to rule out potential metastasis or inflammatory disease)
*** Please continue to ensure that referrals to orthopaedics for Hips, Knees, Ankles and Shoulders include an Xray taken within the last 6 months**

<Insert Details of any investigations so far>

Pathway

☐ Clinical Threshold applies- attached ☐ Completed/direct to Get Fit First pathway

Special Needs to Consider (tick all that apply)

☐ Vision impairment ☐ Physical disability ☐ Female clinician required
☐ Hearing impairment ☐ Learning disability ☐ Male clinician required
☐ Other – please specify ▶

Last Consultation
<Insert last relevant consultation relating to this referral>
<Event Details(table)>

Past Medical History
<Insert past history of similar problems including dates of any investigations or interventions>

Active Problems
<Insert any ongoing health issues. State if the patient is currently receiving any other medical care, investigations or treatment>
<Problems(table)>

Current Acute Medication
<Insert any newly prescribed medication e.g. prescribed in the last three months>
<Medication(table)>

Current Repeat Medication
<Insert any medication on repeat prescription>
<Medication(table)>
<Repeat Templates(table)>

Allergies
<Insert any known allergies or state 'no known allergies'>
<Allergies & Sensitivities(table)>

Latest BMI: <Latest BMI> **Alcohol:** <Numerics> **Smoking status:** <Diagnoses>

Recent Pathology
<Insert any recent pathology in the last four months including bloods>

<Pathology & Radiology Reports(table)>

Diabetic ☐ <Numerics>