**Spinal Clinician Referral Form**

**\*The case will not be accepted for the Virtual Triage Clinic if there is no reported imaging.**

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| **PATIENT DETAILS** | | | | | |
| **Title:** | **Surname:** | | | **First Name:** | |
| **DOB:** | | **Age:** | **NHS no.:** | **Gender:** | |
| **Address:** | | | | **Tel No.:**  **Email address:** | |
|  | | | | **ECOG Score:**  **MJOA Score:**  **(Myelopathic patients)** | |
| **Language:** | | | | **Interpreter required: Y N** | |
| **Special requirements:** Accessibility needs:  <Diagnoses> <Diagnoses> Hearing: <Diagnoses> Vision: <Diagnoses> | | | | **Carer status:** | |
| **REFERER DETAILS** | | | | | |
| **Referring Service:** | | | | | **Referrer name:** |
| **Email address:** | | | | | **Date of Referral:** |

Urgent  Routine

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **CLINICAL DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Reason for**  **referral:** | | | Clinical signs / symptoms:  Reason for referral & working diagnosis:  Pre-referral examination & management:  Any other information: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the patient had previous comprehensive management for this condition under physiotherapy, rheumatology, pain clinic, or surgery? Please include location, date, and consultant.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physiotherapy** | | | | |  | | | Location: | | | | | | | | | Date: | | | | | | Consultant: | | | | | |
| **Rheumatology** | | | | |  | | | Location: | | | | | | | | | Date: | | | | | | Consultant: | | | | | |
| **Pain clinic** | | | | | |  | | Location: | | | | | | | | | Date: | | | | | | Consultant: | | | | | |
| **Surgery** | | | | | |  | | Location: | | | | | | | | | Date: | | | | | | Consultant: | | | | | |
| **Additional Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **What investigations has the patient had associated with this referral?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **X-ray** |  | | | **Blood tests** | | | | |  | | **Neurophysiology** | | |  | | | | **MRI Private** | | |  | | | **MRI NHS** | |  | **NRB** |  |
| **Other**  **(please state)** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **IMAGING\* - Please send all relevant images through IEP at point of referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Where completed | | | | | | |  | | | | | | | | | Date completed | | | | Degenerative stenosis, no more than 18 months. Acute discs, no more than 6 months. | | | | | | | | |
| Contra indication for MRI | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Investigation results | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Pacemaker | | | | | | | **Y  N** | | | | | | Spinal Cord Stimulator | | | | | | | | | | **Y  N** | | | | | |
| DBS | | | | | | | **Y  N** | | | When: | | | Where: | | | | | | | | | Make: | | | | | | |
| **Purpose of referral & referrer/patient expectations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis | |  | | | | | Investigation | | |  | | Treatment | | |  | | | | Suitable provider | | | | | |  | | | |
| **If you believe surgery is required, does the patient want to undergo surgery? Y N** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **PAST HISTORY** | |
| **Medical problems, please include comorbidities** | |
| Current | Click or tap here to enter text. |
| Past |  |
| Family history | |
|  | |
| **MEDICATION** | |
| Current repeats |  |
| Current acute |  |
| **Factors to consider including social factors**  *e.g. sleep disturbance, has the patient been off work* | |
|  | |

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| --- | --- | --- | --- |
| **HEALTH CHECK** | | | |
| Blood pressure | <Latest BP> | BMI |  |
| Heart rate & rhythm |  | Smoking status |  |
| Height | <Latest height> | Alcohol intake |  |
| Weight | <Latest weight> | Exercise tolerance |  |
| **ALLERGIES AND SENSITIVITIES** | | | |
|  | | | |