**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** |
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