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| **IES MSK SERVICE** | |
| [AHP Suffolk](https://www.ahpsuffolk.co.uk/Home.aspx) | [Ipswich Hospital Logo](http://www.ipswichhospital.nhs.uk/) |
| **REFERRAL DATE:** | **Patient’s Email:**  **Patient’s Telephone:** |

\*Please use self-management guidance for MSK conditions prior to referral to IES MSK Service [www.iesmsk.co.uk](http://www.iesmsk.co.uk).

\*Please use advice & guidance on e-referral if appropriate.

MUSCULOSKELETAL SERVICES REFERRAL

Please complete ALL sections of the form, incomplete forms will be returned.

No appointments can be made until a **FULLY COMPLETED** form has been received.

Once completed send this form to the appropriate service via the ‘NHS e-Referral Service’:  
**AHPS/IES MSK Single Point of Access Service -** Speciality: **Physiotherapy** - Clinic Type: **Musculoskeletal**

The referral will be triaged and sent to the appropriate healthcare professional for assessment, diagnostics and further management as required.

Please attach any additional relevant information & the mandatory forms as advised below the relevant service.

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| **OA Hip / Knee** |  | - |
| **Paediatric** |  | - |
| **Soft Tissue Knee / Hip** |  | - |
| **Upper Limb** |  | Please attach upper limb threshold form if applicable |
| **Spine** |  | Please attach spinal red flag form if applicable |
| **Foot & Ankle** |  | Please attach first ray (bunion) surgery threshold form if applicable |
| **Rheumatology** |  | Additional rheumatology referral form required |
| **Pain Management** |  | Additional pain referral form required |

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| **Routine** | **Urgent** | **Red Flag** |
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| ***Patient Details*** | **DOB:** | | **NHS Number:** |
| **Surname:** | **First name:** | | **Gender:** |
| **Address:** | | **Daytime No:**  **Home Tel No:** | |
| **Interpreter required?** Yes  No  **If yes, what language:** | | | |
| **Transport required?** Yes  No | | | |

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| **Problem/Provisional Diagnosis:** | | | | | | |
| **Patient Expectation:** | | | | | | |
| **Duration:** | Under 2 weeks  2 – 6 weeks  Over 6 weeks  Over 1 year | | | | | |
| **Has this patient failed to benefit from previous physiotherapy treatment for this condition** Yes  No | | | | | | |
| **Recent Relevant Investigations:** X-ray  MRI  CT  Blood Tests  Ultrasound  Other  Please attach results | | | | | | |
| **Past Medical History**  **(Please list all below)** | | Diabetes  HbA1C: | Inflammatory disease | Cancer | Respiratory | Cardiovascular |
| Depression | Anticoagulant Therapy | BMI: | Blood Pressure: | Learning Disabilities |
| *Attached.* | | | | | | |
| **Medication (please list all medication)**  *Attached.* | | | | | | |

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| ***Referring GP Details*** | |
| **Name:** | **GP Code:** |
| **Practice:** | **Tel:**  **Fax:**  **Email:** @nhs.net |