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| **IES MSK SERVICE** |
| AHP Suffolk | Ipswich Hospital Logo |
| **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 |