# NHS Musculoskeletal Referral Form

# (Incorporating MCATT’s, Orthopaedics and non-inflammatory Rheumatology referrals)

**\*Excludes routine physiotherapy, fracture clinic, urgent A&E referrals and suspected cancer 2 week wait**

**If patient requires physiotherapy please refer directly, not via this MCATTS form**

**To access this service use Choose and Book (preferred), Email completed forms to: gst-tr.mcats@nhs.net**

**Guys and St Thomas’ NHS FT**

Musculoskeletal Service Guy’s & St. Thomas’

3rd Floor Lambeth Wing

St. Thomas Hospital

Westminster Bridge Road SE1 7EH

Email : [gst-tr.MCATs@nhs.net](mailto:gst-tr.MCATs@nhs.net)

🕾: 020 7188 7612

Fax: 020 7188 5092

**Kings College Hospital NHS FT**

MCATS

Therapy Suite, 1st Floor Golden Jubilee Wing

Kings College Hospital, Denmark Hill,

London, SE5 9RS

Email: [kch-tr.mskCATS@nhs.net](mailto:kch-tr.mskCATS@nhs.net)

🕾: 020 3299 8213

Fax: 020 3299 3843

## Patient Details

**Title: ~[Title] Name: ~[Forename] ~[Surname] DoB:** **~[Date Of Birth] Sex: ~[Sex]**

**Address: ~[Patient Address Line 1] ~[Patient Address Line 2] ~[Patient Address Line 3] ~[Patient Address Line 4]** **~[Post Code]**

**Home Telephone No: ~[Telephone Number]** **Mobile:** **~[Mobile No.]** **Work:**

**NHS Number (if known): ~[NHS Number]**

**Interpreter required YES**  **NO** **If yes, which language**?

**Is patient off work due to this problem pain? YES NO If yes, how long for?**

|  |  |  |
| --- | --- | --- |
| **Provisional diagnosis (including any specific indication for direct referral to ortho/rheum):**    **Would this patient consider surgery for this problem if appropriate? YES  NO** | **Anticipated Initial review by:**  Any  **Or would prefer**  MSK CATS  Orthopaedics  Rheumatology  **OR**  **Specific Clinician if appropriate:** | |
| **Please mark symptom distribution on chart**  **Unlock the form:**  **- Office 2003: click on View, Toolbars, Forms and click on padlock,**  **- Office 2007: click on Developer, Protect Document, Restrict formatting, Stop Protection, then drag and drop the crosses** | **What clinical question do you want answered by this referral?**    **Clinical presentation/history**    **PTO** |

## Current Episode of Spinal Pain

**Duration of Symptoms <6/52  6/52–3/12  3/12-6/12  >1year**

**Acute 1st Episode**

**Acute Exac / Chronic condition**

**Onset: Spontaneous Following minor back strain  Following major injury**

**Relevant Investigations:**

|  |  |  |  |
| --- | --- | --- | --- |
| **X-ray**  **Scans**  **Blood Test** | Lower Limb Xrays in weight- bearing. PLEASE ATTACH REPORT | When | Where |

**Relevant PMH**

|  |
| --- |
|  |

**Current/Previous treatment/Drug allergy**

**~[Allergies]**

**~[Medication]**

|  |  |
| --- | --- |
| **Medication**  **Physiotherapy**  **Other** |  |

**RED FLAGS**

|  |  |  |
| --- | --- | --- |
| **Weight loss(more than 10% of body weight in 3-6/12)**  **Severe, unremitting night pain**  **Fever**  **Gait disturbance**  **History of serious pathology**  **systemic illness e.g. malignancy**  **Structural deformity**  **Bilateral changes in sensation in hands +/-**  **Feet lower limb hyper-reflexia +/- clonus** | **Inflammatory presentation**  **Night pain Multiple jt pain**  **Resting pain AM stiffness**  ***(How long?)***  **History of? Iritis Inflam bowel**  **Urethritis Psoriasis**  **Family Hx of inflamm disease**  **Abnormal abdominal examination**  **Lumps and Bumps (ganglions, masses)** | |
| **Neurological Signs present Cx/Tx spine?**  **Sensory loss Dysphasia**  **Muscle weakness Dizziness**  **Altered Reflex Drop attacks**  **Nausea Dysarthria**  **Severe and constant headache** | **Neurological Signs present Lx spine?**  **Sensory loss**  **Muscle weakness**  **Altered Reflex**  **Positive SLR** | |
| **\*\*PLEASE DO NOT USE THIS FORM FOR ROUTINE PHYSIOTHERAPY. PLEASE REFER PATIENTS DIRECTLY TO GENERAL PHYSIOTHERAPY IN THE FIRST INSTANCE.** | |
| GP Name:       Practice Address: ~[Surgery Address Line 1] ~[Surgery Address Line 2] ~[Surgery Address Line 3] ~[Surgery Address Line 4] ~[Surgery Address Line 5] ~[Surgery Tel No.] Lambeth 🞏 Southwark 🞏 | | |
| **Signature:**       **Date:** ~[Today...] | | |

**\*Incomplete forms will delay patient assessment and may be returned to the referrer\***