Care Co-ordination Centre

Physiotherapy Outpatient Service Referral Form

(Musculoskeletal)

Telephone: 0300 1310 111 **Email:** provide.ccc@nhs.net

Note: Provide services work to NHS Connecting for Health policies and can only send responses including patient identifiable details (PID) to email addresses that are approved by them. If you are not using an approved email address this may limit the response we can make by email.

Turn on Form Protection above prior to completion then click the relevant boxes for the referral. When all of the relevant boxes have been ticked turn off form protection to write notes into the form prior to saving.

Date of referral:	NHS number:
Patient details	
Forename:	Surname:
Address and postcode:	
Date of birth:	Gender:
Home telephone:	Mobile telephone:
Preferred contact number:	Ethnicity:

☐	Learning disability	☐	Physical impairment	☐	Sensory impairment
☐	Mental health condition	☐	Longstanding illness	☐	Others

Add details:

Interpreter required	☐	No		☐	Yes		
Shortest wait (any site)	☐	Braintree	☐ Halstead	☐	Maldon	☐	Chelmsford

Reason for referral

Please provide as much information as possible in relation to the nature and duration of symptoms

*If this is a referral for back pain ensure STarT Back questionnaire is completed**

Onset of symptoms	Work status
☐ 0 - 2 Weeks	Has the patient recently become unfit for work due to this problem?
☐ 2 - 8 Weeks	☐ Yes ☐ No ☐ Unemployed/retired
☐ > 8 Weeks (Print date of onset below)	Is the patient unable to care for a dependent due to their present condition?
Date of onset:	☐ Yes ☐ No

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Has the patient been seen by Physiotherapy for this problem within the last six months?			
☐ Yes		☐ No	
Is this a chronic condition that the patient has had for over 6 months?			
☐ Yes		☐ No	
If yes to either of the above, please explain why further physiotherapy is deemed appropriate:			
Recent investigations/interventions and summary of findings			
☐ Steroid injection Date:	☐ X – Ray Include results where possible	☐ MRI Include results where possible	
☐ CT	☐ Blood Test	☐ Other	
Medical history (including current medication)			
Major active problems for medical history:			
Relevant previous medical history:			
Current repeat templates for prescriptions:			
Allergies and sensitivities:			
Requirement of Transport			
☐ Yes	☐ No		
Referrer details (completed if not patient's GP)		☐ Select if patient's GP	
Print name:		Job role:	
Organisation/service:		Contact number:	

Please send your completed referral form by email to: provide.ccc@nhs.net

Please complete the form as thoroughly as possible to ensure your patient is triaged appropriately. Referrals with an insufficient data set will be returned. Patients with referrals for back pain without a STarT Back questionnaire will be returned in accordance with our service specification

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