|  |  |
| --- | --- |
| * ***Malignancy suspected-refer under 2-week rule Link to 2 week rule form*** * ***Suspected fracture- refer to A&E*** * ***Inflammatory arthritis- refer urgently to early inflammatory pathway***   Urgent and Emergency Musculoskeletal Conditions Requiring Onward Referral: http://arma.uk.net/wp-content/uploads/2021/01/Urgent-emergency-MSK-conditions-requiring-onward-referral-2.pdf |  |

**SWL ORTHOPAEDIC REFERRAL FORM: SHOULDER**

**SECTION 1**

|  |  |
| --- | --- |
| DATE |  |
| **Name:** |  |
| **NHS Number:** |  |
| **Date of Birth:** |  |
| **Gender:** |  |
| **Ethnicity:** |  |
| **Address:** |  |
| **Tel:** |  |
| **Email:** |  |
| REFERRER DETAILS |  |
| **Name:** |  |
| **Role: (GP, FCP, ACP, Consultant)** | Choose an item. |
| **Practice Code or referrer address:** |  |
| **Contact details (phone/e-mail):** |  |

|  |  |
| --- | --- |
| **COMMUNICATION & ASSISTANCE** | YES |
| **Does the patient require an interpreter?**  ***If yes, which language?*** |  |
| **Is the patient suitable for a telephone or video consultation?**  ***If no, please provide details*** |  |
| **Does the patient require Patient Transport?** |  |
| **Does patient have access to a smart phone to receive SMS/ Video Consultations?** |  |

ONWARD REFERRALS

Preferred Provider: CUH, ESH, KH, SGH, SWLEOC Choose an item.

**SECTION 2**

REASON FOR REFERRAL

Past Medical History

Drug History

|  |  |
| --- | --- |
| **REASON FOR REFERRAL**  **Shoulder** |  |
| **Side** | YES |
| **Right** |  |
| **Left** |  |
| **Bilateral** |  |
| **Symptoms and Effects on Quality of Life** |  |
| **Pain** |  |
| **Are activities of daily living significantly compromised?** |  |
| **Is this causing a functional problem?** |  |
| **Sleep disturbance** |  |
| **Details of Previous Treatment Related to this Condition** |  |
| **Analgesia** |  |
| **Activity Modification** |  |
| **Physio Led Rehabilitation for minimum 12 weeks** |  |
| **150 minutes of moderate exercise a week** |  |
| **Injections**  **If Yes, how many?** |  |
| **BMI** |  |
| **Weight loss advice (if BMI > 30)** |  |
| **Current smoker** |  |
| **Smoking ceasing advice (if applicable)** |  |
| **Patients Expectations** |  |
| **Rehabilitation** |  |
| **Surgery** |  |
| **Injection** |  |

|  |  |
| --- | --- |
| **Sub-Speciality Questions** | YES |
| **Pain around shoulder for at least 6 weeks?** |  |
| **Significant weakness?** |  |
| **Significant stiffness in shoulder, limiting range of movement?** |  |
| **Symptomatic instability** |  |
| **Patient has been engaged in shared decision making to ensure he/ she is well informed about the treatment options available and personal values, preferences and circumstances are taken into consideration** |  |
| **Confirmed willingness to have surgery within the next 18 weeks, if deemed appropriate?** |  |

|  |  |
| --- | --- |
| **DIAGNOSTICS** | **YES** |
| **X-ray:**  **True AP (Grashey view) and Axillary lateral**  **Please reserve MRI and USS for Secondary Care** |  |
| ***Please include date and location so images can be accessed***  Date:  Venue: |  |