

## NEUROSURGERY SPINE MDT REFERRAL FORM

### Are there any 'Red Flag' symptoms present?

**This form is for non-emergency referrals only.** Red flag cases require urgent assessment and should be immediately referred to A&E or discussed with Neurosurgery on-call via telephone. Please **do not** refer red flag cases to the MDT unless advised to do so by on-call or A&E.

**Referrals are first reviewed and triaged by the Spinal Multiple Disciplinary Team (MDT) administrator (non-clinical). If surgery is not recommended, an outpatient appointment will not be offered.**

**The purpose of the MDT is to identify patients with signs and symptoms of nerve root or spinal cord compression, which may be amenable to surgical intervention. Patients with isolated neck or axial back pain without nerve compression are not accepted. If surgery is not recommended, an outpatient appointment will not be offered.**

**Referral acceptance criteria:**

- Details of the patients' symptoms and their clinical history - including what has been tried already, such as physiotherapy or pain management.
- The symptoms you are asking the surgery team to treat.
- MRI imaging must be undertaken within last 6 months or less. Any referrals with imaging older than this time frame will not be accepted. Details of the location where the scan was undertaken are required in order to obtain copies of the images. A CD copy of MRIs taken overseas or privately is required when referring to the MDT.
- Only referrals from hospital trusts and community MSK Triage and Treat Team (TTT) will be accepted via email.
- GP must direct patients to community MSK Triage and Treat Team using this referral form. No direct referrals from GP practices are accepted. TTT makes the referrals via electronic referral system (eRS).
- Incomplete forms will be returned resulting in delays to the patients' care.

**ALL FIELDS OUTLINED IN RED MUST BE COMPLETED.**

Please email form to: [kch-tr.spinemdt@nhs.net](mailto:kch-tr.spinemdt@nhs.net)

Patient Details		Hospital/GP Details	
Full Name:		Date of Referral:	
Date of Birth:		Name of referrer:	
NHS Number:		Hospital:	
Address:		Department:	
		Email address:	
Email address:		GP Name/ Address:	

Home  Hospital  Care Home

YES  NO If yes, please specify:

**Clinical History and Symptoms**

**Brief clinical history of presenting complaint. Please be concise and give only relevant details as to why patients' presentation is amenable for neurosurgical opinion:**

**What specific questions would you like this MDM to answer?**

<6 weeks  6-12 weeks  >3 months  >6 months  >1 year

**Neuro Examination Findings:**

Does the patient have normal power in upper and lower limbs? Yes No  
If no, please fill form below (MRC Muscle power grade 0-5) :

Upper limb Right		Upper limb left		Lower limb Right		Lower limb Left	
Shoulder abduction		Shoulder abduction		Hip flexion		Hip flexion	
Elbow flexion		Elbow flexion		Hip extension		Hip extension	
Elbow extension		Elbow extension		Knee Flexion		Knee Flexion	
Wrist flexion		Wrist flexion		Knee extension		Knee extension	
Wrist extension		Wrist extension		Ankle dorsiflexion		Ankle dorsiflexion	
Finger abduction		Finger abduction		Plantar Flexion		Plantar Flexion	

Does the patient have sensory changes? Yes No

Does the patient have reflex changes? Yes No

Symptoms of spinal claudication: Yes  No   
Symptoms of cervical/thoracic myelopathy: Yes  No   
Does the patient have Sphyncter dysnfuction? Yes No

**Imaging and Other Relevant Investigations**

MRI Scan : Yes  No  Date of the scan :

Location  
of scan:

CT Myelogram: Yes  No  Date of the scan :

Images sent to Kings PACS: Yes  No

Please transfer images to Kings PACS/IEP for quicker processing of referral.

Physiotherapy       Pain clinic

Did the patient have an injection under the pain clinic? Yes  No

If yes, please specify the injection : \_\_\_\_\_

Previous Spinal Surgical procedure: Yes  No

Year of Surgery:

Type of Surgery:

Where surgery has been performed and name of consultant?:

Co-morbidities: (Please choose from drop down lists below)

Respiratory

Cardiac:

Other:

Details:

Additional Information that may be useful to us (optional):

Please email completed form to: [kch-tr.spinemdt@nhs.net](mailto:kch-tr.spinemdt@nhs.net)