**NEUROSURGERY SPINE MDT REFERRAL FORM**

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| |  | | --- | | **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 who is 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*

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| **Patient Details** | |  | **Hospital/GP Details** |
| Full Name: | Click or tap here to enter text. | Date of Referral: | Click or tap here to enter text. |
| Date of Birth: | Click or tap here to enter text. | Name of referrer: | Click or tap here to enter text. |
| NHS Number: | Click or tap here to enter text. | Hospital: | Click or tap here to enter text. |
| Address: | Click or tap here to enter text. | Department: | Click or tap here to enter text. |
| Email address: | Click or tap here to enter text. |
| Email address: | Click or tap here to enter text. | GP Name/ Address/ Email : | Click or tap here to enter text. |

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| Current location of patient:  Home  Hospital  Care Home |  |
| Does the patient require a translator?  YES  NO | If yes, please specify:  Click or tap here to enter text. |
| **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?**  Click or tap here to enter text.  Duration of symptoms: *<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 | Click or tap here to enter text. | Shoulder abduction | Click or tap here to enter text. | Hip flexion | Click or tap here to enter text. | Hip flexion | Click or tap here to enter text. | | Elbow flexion | Click or tap here to enter text. | Elbow flexion | Click or tap here to enter text. | Hip extension | Click or tap here to enter text. | Hip extension | Click or tap here to enter text. | | Elbow extension | Click or tap here to enter text. | Elbow extension | Click or tap here to enter text. | Knee Flexion | Click or tap here to enter text. | Knee Flexion | Click or tap here to enter text. | | Wrist flexion | Click or tap here to enter text. | Wrist flexion | Click or tap here to enter text. | Knee extension | Click or tap here to enter text. | Knee extension | Click or tap here to enter text. | | Wrist extension | Click or tap here to enter text. | Wrist extension | Click or tap here to enter text. | Ankle dorsiflexion | Click or tap here to enter text. | Ankle dorsiflexion | Click or tap here to enter text. | | Finger abduction | Click or tap here to enter text. | Finger abduction | Click or tap here to enter text. | Plantar Flexion | Click or tap here to enter text. | Plantar Flexion | Click or tap here to enter text. |   Does the patient have sensory changes? Yes  No  **If yes, please specify:**  Click or tap here to enter text.  Does the patient have reflex changes? Yes  No  **If yes, please specify:**  Click or tap here to enter text.  Symptoms of spinal claudication: Yes  No  Symptoms of cervical/thoracic myelopathy: Yes  No  Does the patient have Sphincter dysfunction? Yes  No  **If yes, please specify:**  Click or tap here to enter text.   |  | | --- | | **Imaging and Other Relevant Investigations.** | | **MRI Scan : Yes  No**  Date of the scan: Click or tap here to enter text.  Location of scan: Click or tap here to enter text.  **CT / CT Myelogram: Yes  No**  Date of the scan: Click or tap here to enter text.  Location of scan: Click or tap here to enter text. | | **Images sent to Kings PACS: Yes  No**  **Please transfer images to Kings PACS/IEP for quicker processing of referral.** | | Previous conservative treatments (within last 3-6 months): Yes  No  PhysiotherapyPain clinic  Did the patient have an injection under the pain clinic? YesNo  **If yes, please specify the injection :**  Click or tap here to enter text. | | **Previous Spinal Surgical procedure: Yes  No**  Year of Surgery: Click or tap here to enter text.  Type of Surgery: Click or tap here to enter text.  **Where surgery has been performed and name of consultant?**  Click or tap here to enter text. | | |

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| **\* Co-Morbidities: (Please select appropriate)**  **Respiratory**  Details :  **Cardiac** :  HTN , Angina Ischaemic Heart disease,  AF, Valve disease, Heart failure,  Other ,  None  Details :  **Other** :  Diabetes,  Renal Impairment,  Hepatic disease,  Other co-morbidities,  None  Details : |
| **Additional Information that may be useful to us** (optional)**:**  Click or tap here to enter text. |

**Please email completed form to: kch-tr.spinemdt@nhs.net**