*Please send form to:* [*kch-tr.neurosurgeryfractures@nhs.net*](file:///C%3A%5CUsers%5Cjade_%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CDI8VSZ7C%5Ckch-tr.neurosurgeryfractures%40nhs.net)

**Neurosurgery Spinal Fracture Outpatient Request Form**

**This form is for referrals previously discussed with Neurosurgery Acute on-call only.** Information provided in this referral form should follow instructions previously given by on-call. Please direct any further clinical questions to the on-call team on 0203 299 4207.

All other forms can be found our website: <http://www.kch.nhs.uk/gps/referral-forms>

|  |  |
| --- | --- |
| **Patient Details** | **Referrer Details** |
| Surname |  | Referring Hospital | Choose an item. |
| Forename  |  | Name of Referrer |  |
| Date of Birth  |  | Designation  |  |
| NHS Number |  | Email  |  |
| Address |  | Bleep/Mobile  |  |
| Postcode |  | Consultant Name  |  |
| Consultant Email  |  |
| GP Name  |  |
| Tel No.  |  | Practice Address |  |
| Mobile No.  |  |
|  |
| GP Tel No  |  |

|  |
| --- |
| **Clinical Details** |
| **Date of Referral:** Click or tap to enter a date. | **Date of Injury:** Click or tap to enter a date. |
| 1. **Mechanism of Injury**

[ ]  RTA[ ]  Fall[ ]  Other: Click or tap here to enter text. |
| 1. **Level of Injury** – please tick the relevant box

Occipital condyle: Yes [ ]  No [ ] C1 - C7: Yes [ ]  No [ ] C1 - C7: Click or tap here to enter text.T1-T12: Yes [ ]  No [ ] T1-T12: Click or tap here to enter text.L1-L5: Yes [ ]  No [ ] L1-L5: Click or tap here to enter text. |
| 1. **Other Associated Injuries:** N/A[ ]

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| 1. **Neurological Deficit:** Yes [ ]  No [ ]

If yes, please complete below. Otherwise, continue to number 7. Sensory Deficit: Choose an item. Click or tap here to enter text. Motor Deficit: Choose an item. Click or tap here to enter text.  |
| 1. **Bowel/Bladder Dysfunction:** Yes [ ]  No[ ]
 | 1. **ASIA Score:** Choose an item.
 |
| 1. **Osteoporosis:** Yes [ ]  No [ ]
 | 1. **Current Treatment of Osteoporosis:**

Yes [ ]  No [ ]  |
| 1. **Anticoagulants:** Choose an item.
 | 1. **Antiaggregating Medicine**: Choose an item.
 |
| 1. [***Frailty Score***](https://www.nice.org.uk/guidance/ng159/resources/clinical-frailty-scale-pdf-8712262765)**:** Choose an item.
 |
| 1. **Advice from on-call:**

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| **Consultant Name:** Choose an item. | **OPA Time Frame:** Click or tap here to enter text. |
| **Brace:** Yes [ ]  No [ ] **Type of Brace:** Choose an item. | **Scans Completed****All scans must be completed within the last month to be considered for discussion at the MDT (Multi-Disciplinary Team) Meeting.**  | **Date Completed** |
| Choose an item. | Click here to enter a date. |
| Choose an item. | Click here to enter a date. |
| Choose an item. | Click here to enter a date. |
| Choose an item. | Click here to enter a date. |

 Please check all sections have been completed before sending. Any referrals that are not complete or do not fit the required criteria will be returned. Thank you for your co-operation.