*Please send form to:* [*kch-tr.neurosurgeryfractures@nhs.net*](file:///C:\Users\jade_\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\DI8VSZ7C\kch-tr.neurosurgeryfractures@nhs.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 | | | |
| 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:** | | | |
| **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.