

**Pennine-Lancashire Integrated Musculoskeletal Service
Single Point of Access Referral Form**

All GP enquiries please contact the PLIMS GP Advice Line: 01254 736041

Date of Referral:		Referred by:	
Title: Mr / Mrs / Ms / Miss / Other		GP / Referrer Address:	
Surname:			
Forenames:			
Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB:	NHS No:
Patient Address:		Hospital Number:	
Postcode		Does the patient have any language, hearing or other supportive needs? No <input type="checkbox"/> Yes <input type="checkbox"/> Details: _____	
Home number:		Main language spoken: _____	
Daytime number:		Interpreter required: No <input type="checkbox"/> Yes <input type="checkbox"/>	
Mobile number:		Details: _____	
UK Resident Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Referral Priority: Does the patient meet the URGENT criteria including:			Yes - Urgent <input type="checkbox"/> No - Routine <input type="checkbox"/>
• Red Flags <input type="checkbox"/>	• Inflammatory Disease <input type="checkbox"/>		
• Vertebral Fracture <input type="checkbox"/>	• Complex Regional Pain <input type="checkbox"/>		
• Cancer Diagnosis Suspected <input type="checkbox"/>			
Please identify the reason for referral and provisional diagnosis: 			
Please indicate referral pathway preference			
• Physiotherapy / MSK <input type="checkbox"/>	• Rheumatology <input type="checkbox"/>		
• Pain Management <input type="checkbox"/>	• Orthopaedics <input type="checkbox"/>		
• Orthotics <input type="checkbox"/>			
Height:	Weight:	BMI:	
Alerts / Warnings / Allergies: 			
Patient information			
• Please confirm that the patient has exhausted simple first line management as outlined in the local pathways			Yes <input type="checkbox"/> No <input type="checkbox"/>
• Has the patient been provided with a Decision Aid for Pain Management			Yes <input type="checkbox"/> No <input type="checkbox"/>

Presenting problem

- History of present condition
- Previous Assessments
- Treatments & Outcomes
- Investigations
- Past Medical History
- Current Medication
- Is the patient unable to work or struggling with work?
- Are they struggling to sleep?
- Do they have mental health problems?
- What are the patients' expectations?
- Details of previous consultant appointments

Please include clinical details or attach Referral letter