NORFOLK & WAVENEY COMMUNITY MSK SERVICES REFERRAL

Completed referrals (except for MATS) to be emailed to: nowmsk@ecchcic.nhs.uk
Tel: 01493 809 977

MATS referrals ONLY to be uploaded into NHS e-Referral (Choose and Book)
Selecting the option:
Norfolk & Waveney Musculoskeletal Assessment and Triage Service (MATS)

MATS service available for Great Yarmouth & Waveney, Norwich, South and West Norfolk

Exclusions: Patient who meet any of the following conditions are not appropriate for referral and therefore not covered in this service:

- Non-MSK Neurological Conditions
- Chest physio.
- Patients that require emergency treatment.
- Patients exhibiting red flag symptoms requiring immediate referral to secondary care.
- Patients requiring access to one of the Norfolk and Waveney Fast Track Pathway.
- Continence and Women's/Men's Health.
- Housebound patients – refer to local domiciliary service.

NB. Acceptance of paediatric referrals varies – details can be found on our website:
norfolkandwaveneycommunityhealth.nhs.uk/msk/healthcare-practitioners

Please note – it will aid the referral management process if all relevant sections are completed.

Please indicate which service is required:	
☐ Musculoskeletal Outpatient Physiotherapy	☐ Musculoskeletal Assessment and Triage (MATS)
☐ Musculoskeletal Biomechanics (Foot & Ankle)	*for assessment of non-red-flag Orthopaedic, Rheumatology and MSK Pain Services referrals to secondary care*
☐ Musculoskeletal Hand Therapy	

Referral Information:	Date of referral:
Referral Reason:	
Outcome of next steps conversation with patient, to include specific patient care expectations if flagged	

Patient Details			
Name:		Address:	
NHS No.:			
Date of Birth:			
Tel No.:			
Gender:			
Ethnic Origin:			
Veteran:	☐ Yes / No ☐	Postcode:	
Current BMI:		Smoker:	☐ Yes / No ☐

Accessible Information Standards	
Please specify below if the patient has additional needs related to:	
Vision	Speech
Hearing	Other communication difficulties

The patient requires an:

☐ Interpreter (*specify language*) ☐ Lip speaker ☐ BSL interpreter

Referrer Details			
Referrer Name:		Organisation:	
Designation:		Contact No:	
Email:			
Consultant:		Hospital:	

GP Practice and Consultant Details			
GP Practice:		Practice Address:	
Practice Email:			
Practice Tel No.:		Postcode:	

Additional Referral Information
Weight-bearing status:
Is patient off work due to current symptoms? If yes, how long:
Is patient a main carer? If yes, are symptoms affecting their ability to perform role:
Are other professionals involved in this episode of care?
Relevant/Pending investigation:
Any known risks?
Any reason why the patient cannot participate in a group / class?

Relevant Medical Information
Current Medication:
Past Medical History:

* For Hip and Knee referrals to Secondary care (via MATS) - Modified NZ Questionnaire **completion is required for Secondary Care and will expedite onward referral, reducing any potential delays** and is included at the bottom of this form

Modified Hip and Knee Osteoarthritis New Zealand Score (to be completed as appropriate)			
Joint Affected *Please mark as appropriate*	☐ Hip	☐ Knee	☐ Left / Right ☐
Please quantify the following:		**Score**	**Please enter relevant score below**
1 **How bad is your hip/knee pain?** • None • Mild (occasional pain with longer walks) • Moderate (pain with most activity and walking) • Severe (constant pain – little relief and/or giving way)		0 1 3 5	
2 **How bad is your night pain?** • None • Mild (doesn't wake you) • Moderate (occasionally wakes you) • Severe (regularly wakes you)		0 1 3 5	
3 **How far can you walk?** • Unlimited • ½ to 1 mile • ¼ to ½ mile • Less than ¼ mile		0 1 3 5	
4 **How often do you need painkillers?** • Occasionally • Regularly		0 3	
5 **Is your pain getting worse?** • No • Yes		0 3	
		Total Score:	