**Referral Criteria**

* Patients must have a neurological diagnosis as primary presenting complaint
* Patient must be aged 16 years of age or over
* Spasticity is having a clear negative impact on the patient
* There must be a clear treatment goal indentified by the patient / referrer

Referral to the Lothian Spasticity Service may be made by any healthcare professional.

Referral to the Lothian Spasticity Service should be made by completion of this referral form.

**Please complete all fields** – incomplete referral information will result in delay in referral being accepted.

Completed forms can be returned as follows:

By email: [AAH.spasticitymanagement@nhslothian.scot.nhs.uk](mailto:AAH.spasticitymanagement@nhslothian.scot.nhs.uk)

By post: Dr. Alyson Nelson, Consultant in Rehabilitation Medicine, Astley Ainslie Hospital

Please note that the Lothian Spasticity Management Service has limited capacity to provide domiciliary assessments. These can only be carried out in exceptional circumstances if a reason is provided.

**What happens next?**

Your referral will be triaged and, if it meets our criteria, an assessment appointment will be sent to your patient.

If referral information is incomplete we will contact you for more information. This will result in a delay in referral being accepted and an appointment being offered.

You will receive information about your patient’s spasticity assessment and management plan following their initial appointment.

**Looking for more information or advice to guide your referral or help you manage spasticity?**

Please visit our Intranet Web Page for information and advice about managing spasticity and when to refer to a specialist spasticity management service. (Add link)

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** |  | | |
| Patient Name: |  | | |
| Address: |  | | |
| CHI: |  | | |
| GP details: |  | | |
| Consultant details: |  | | |
| First Language: |  | Interpreter required: |  |

|  |  |
| --- | --- |
| **Clinical History** |  |
| Primary diagnosis:  *(Include date of onset)* |  |
| Relevant medical history:  *(including cardiac, epilepsy, diabetes, mental health)* |  |
| Social history:  *(including need for care/support)* |  |
| Current medication: |  |
| Known drug allergies: |  |
| Any communication issues: |  |
| Any cognitive issues: |  |
| Current mobility: |  |

|  |  |  |
| --- | --- | --- |
| **Spasticity Information** |  | |
| Body part(s) affected by spasticity: |  | |
| Please provide full information about impact of spasticity on day to day life: | *(May include: pain, function, seating, posture, skin integrity, mobility, body image, personal care, orthotic or splint fit, etc)* | |
| Please provide full information about trigger factors for spasticity: | *(May include: pain, infection, renal calculi, bladder dysfunction, constipation, skin breaks, temperature changes, anxiety, etc)* | |
| Please provide information about any strategies that have already been used to manage this patient’s spasticity and trigger factors: | □Botulinum Toxin  □Phenol  □ Baclofen  □ Tizanidine  □Dantrolene  □Gabapentin/Pregabalin | □Orthotic splint  □ Serial casting  □Surgery  □ Electrical stimulation  □ Other |
| What was the outcome of the above strategies *(if known)*: |  | |
| Please indicate the treatment goals that you/your patient hope to achieve by referral for spasticity management: |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Additional Information** | |  | | | | |
| Does the patient have capacity to consent to treatment? | | □Yes □ No | | | | |
| Is the patient on anticoagulant medication? | | □ Yes □ No  If yes, please give name of anticoagulant:  If yes, please give indication for anticoagulation: | | | | |
| Please provide information about any other key agencies involved with the patient: | |  | | | | |
| Any other relevant information: | |  | | | | |
|  | |  | | | | |
| **Referrer Information** | |  | | | | |
| Name: | |  | | | | |
| Profession: | |  | | | | |
| Address for correspondence: | |  | | | | |
| Contact tel. no: | |  | | | | |
| Referral date: | |  | | | | |
| **For office use only:** | | | | | | | |
|  |  | |  |  |  |  | |
| Date received: |  | |  | Triage outcome |  | Accepted – routine | |
|  |  | |  |  |  | Accepted – priority | |
| Date triaged: |  | |  |  |  | Further information required | |
|  |  | |  |  |  | Advice to referrer re treatment | |
|  |  | |  |  |  | Not accepted – return to referrer | |
|  |  | |  |  |  | Not accepted – sent to another service | |