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| **Name:** |  | **DoB:** |  | | **NHS No:**  **(Mandatory)** |  |
| **Address:** |  | **Tel No:**  **Mobile:** |  | | **Next of Kin contact details:** |  |
| **Reason for Referral:** | | | | **Referral Criteria:**  Spasticity as a result of upper motor lesion  Ability to consent, or ability of appropriate individual to attend appointment to support best interest decision making  **Considerations:**  Clear treatment goals – active or passive  Aggravating factors assessed & optimised i.e. pain, infection, bladder & bowel  Plan for ongoing therapy provision | | |
| **PMH:** *(Please consider cognition)* | | | | **Current Medication:** | | |
| **Goals of intervention:** (*Please consider if these are for active or passive function, what muscles are problematic)*  Reduced extensor spasms to facilitate seating | | | | | | |
| **Current spasticity management plan:** (including plan for ongoing therapy involvement, orthotics, postural management etc.) | | | | | | |
| **Current presentation:** (including range of movement of affected limbs, Modified Ashworth Scale/Tardieu scale, gait pattern, aids etc.) | | | | | | |
| **SH:** (To include level of mobility, accommodation and who lives with them, or other services involved, POA/IMCA) | | | | | | |

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| **Referrer:**  **Email:** | **Profession:** |
| **Date referred:** 31/01/2024  **Please send completed referral to** [**spasticityservice@nbt.nhs.uk**](mailto:spasticityservice@nbt.nhs.uk) | |