**Paediatric MSK Physiotherapy Service Homerton Hospital**

Paediatric Musculoskeletal Physiotherapy, Homerton University Hospital, Homerton Row, London E9 6SR

Tel: 020 8510 7835 Email: hr-tr.paediatricmskphysio@nhs.net

**Referral Criteria:**

* Referrals are accepted for children and young people aged 0 –16 (please note referrals for a child aged 15 years and 9 months old may not be seen prior to their 16th birthday, please consider referring to adult MSK)
* Referrals are accepted from patients who live in and out of borough if referred by a Homerton Healthcare Consultant.
* Out of borough Consultant referrals are accepted if the patient resides in Hackney and has a City and Hackney based GP.
* Children with musculoskeletal problems without neurological concern, with pain, joint restrictions, or functional difficulties- this may include symptomatic hypermobility, Erb’s Palsy, toe walkers with associated pain or functional difficulties, talipes, idiopathic scoliosis, rheumatoid/arthritic conditions, post-operative orthopaedic surgery, gait concerns, joint or muscle pain, ligament injuries/sprains, growth related MSK conditions such as Osgood Schlatter’s Disease (this list is not exhaustive).
* Children with mild motor developmental delay related to musculoskeletal weakness, that are sitting by 10 months, standing by 18 months and walking by 2 years
* Able to access outpatient services and are not confined to their home

**Exclusion criteria:**

* Please note we do not offer serial casting nor provide orthotics or splinting
* Toe walking related to ASD with full range of motion and without pain or functional difficulties, or under the age of 3
* Neurological and/or developmental assessments
* Assessments needed at home or school
* Asymptomatic benign hypermobility with no functional limitations
* Flat feet with no related pain or functional difficulties
* Any resolved trauma with no clinical indication for therapy input/no functional limitations
* Paeds hand specific therapy including congenital disorders and post complex surgery
* Discharged within the last 3/12 for same complaint
* Patients referred after 15 years 9 months of age

**Services provided elsewhere:**

**Foot health:**

* Children who only require foot orthotics.
* Toe walking relating to ASD where orthotics may help with sensory input or with range
* Pain with walking related to flat feet or require shoe raises/orthotics

**Community Paediatric Physiotherapy**

* Children who have a congenital or acquired neurological condition leading to reduced gross motor ability and decreased functional ability
* Children who experience a marked gross motor delay (not in line with global delay) leading to difficulty meeting early developmental milestones e.g., gaining head control, sitting, or rolling which may be due to premature birth or physical difficulties
* Children who require a developmental assessment
* Children who have a muscular condition affecting their gross motor function
* Children with difficulty with balance and higher-level gross motor skills
* Children with global developmental delay who are not sitting at 10 months or not standing at 18 months.
* Children under palliative care to who may require mobility aid/s or positioning advice
* Children with Down’s syndrome
* Children who are unable to access outpatients due to mobility concerns
* Children who require a community assessment at home or school
* Wheelchair assessments, equipment reviews

**Occupational Therapy**

* Concerns for DCD, balance difficulties with a particular motor goal
* Handwriting concerns
* Equipment assessments

**Hand therapy:**

* Children with congenital hand deformities and acquired hand injuries such as burns
* Children who require splinting or specialist hand therapy

Foot health – St. Leonard’s, Nuttall Street, London N1 5LZ

Tel.: 020 7638 4347/4046 Fax: 020 7683 4348 email huh-tr.FootHealthHomerton@nhs.net

Hackney Ark Physiotherapy –

Tel.: 02070147025 Fax. 020 7014 7236 email huh-tr.childrensptreferrals@nhs.net

**Paediatric MSK Physiotherapy Service Homerton Hospital**

**Referral Form**

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Tel: 020 8510 7835 Email: hr-tr.paediatricmskphysio@nhs.net

To make a referral please complete **all** sections of this form. This form must be accompanied by any other available reports or letters (e.g. investigation results, school Drs, statement of educational needs).

**\*Please note, incomplete referrals will be returned\***

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME:** |  | **FORENAME:** |  |
| **DATE OF BIRTH:** |  | **NHS NUMBER:** |  |
| **SEX : MALE** [ ]  **FEMALE** [ ]  |
| **ADDRESS:** |
| **POST CODE:** |  |  |  |
| **ETHNICITY:** |  |  |  |
| **INTERPRETER REQUIRED:** | **YES** |[ ]  **NO** |[ ]  **LANGUAGE:** |  |

**Parents/ Carers Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME:** |  | **FORENAME:** |  |
| **RELATIONSHIP:** |  |  |  |
| **CONTACT DETAILS:** | **Email:** | **Mobile number:** | **Landline:** |
| **Does this family have access to the internet if offered a virtual appointment?:**YES/NO |

**Reason for referral:**

*Please give a description of the difficulties experienced by the child. You may wish to comment on motor skills, sensory difficulties, daily living skills, developmental level, mobility, and posture.*

*Please give as much detail as possible, continue to a separate sheet if necessary.*

|  |
| --- |
| **DETAILS:** |
|  |
| **How do you think physiotherapy will help the child?:**  |
|  |

**Relevant medical history:**

|  |
| --- |
| **CURRENT DIAGNOSIS:** |
|  |
| **PAST MEDICAL HISTORY:** |
|  |
| **RECENT INVESTIGATIONS/MEDICAL REVIEWS:** |
|  |
| **MEDICATION:** |
|  |
| **Any other service involved?:** |
|  |

 **Educational details:**

|  |
| --- |
| **SCHOOL DETAILS:** |
| **SCHOOL** |  | **CLASS TEACHER** |  |
| **TELEPHONE:** |  | **EMAIL ADDRESS:** |  |
| **ADDRESS:** |
| **Does the child have a statement of Educational Needs?:**YES/NO |

**Referrer’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME:** |  | **FORENAME:** |  |
| **TELEPHONE:** |  | **EMAIL ADDRESS:** |  |
| **ADDRESS:** |
| **POST CODE:** |  | **DATE OF REFERRAL:** |  |

|  |
| --- |
| **GP’s DETAILS:** |
| **GP NAME:** | **SURGERY ADDRESS:** |

**All GP referrals must be submitted via E-RS**

**Please note that unless you are sending the email from an (encrypted), secure email account, this method of communication is not secure. If you have any concerns about emailing the referral form back to us, please post the form.**

**If your referral is rejected, you will be notified for the reasons why.**

**Thank you for your referral**