

## The 10 Point Shoulder Referral Form

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**Patient's Name:**

**Date of Birth:**

**Sporting Level** (Please tick):  Nil  Recreational  Competitive  Pro

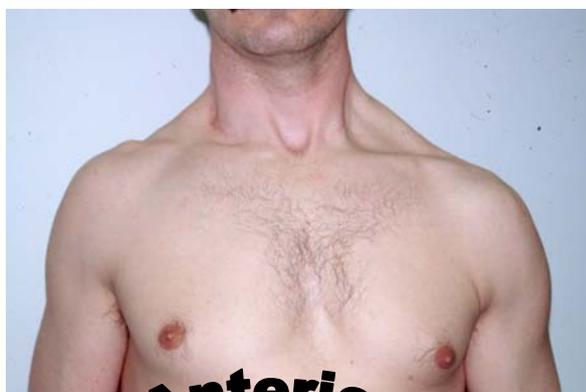
**Symptoms** (please tick one or more): Pain  
Weakness  
Stiffness  
Instability  
Catching

**Are the symptoms injury related ?** :  Y /  N

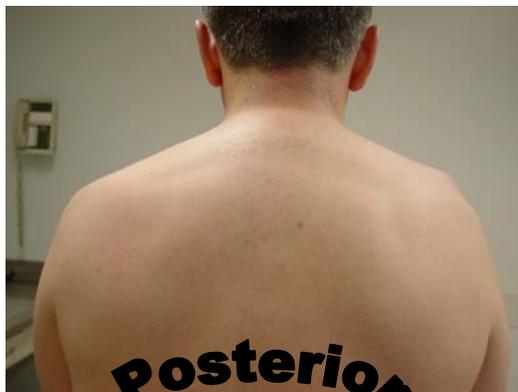
**Does overhead activity make the pain worse ?**

Y /  N

**Please mark the site of maximum pain & / or tenderness on the diagram**



**Anterior** ↗



**Posterior** ↘

**Do your symptoms interfere with sport or activities of daily living or both ?**  Y /  N

**Score your shoulder out of 10 ( 0 is the worst and 10 is the best possible)**  /10

**Clinical Impression:**