

## **Physiotherapy Self-Referral Form**

*Please Note* – This form should be used to access Physiotherapy for **one** musculoskeletal complaint/condition. If you have multiple joint or muscle pains please contact your GP for advice.

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| **Title**:\_\_**Surname**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First names** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **NHS NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date Of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(If you are under 16 years of age a direct referral from your GP is required) |
| **Address:** | DaytimeContact telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Postcode**:\_\_\_\_\_\_\_ | **GP Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**     **GP Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Are you off work because of this problem?** ○Yes○No ○Don’t Work**Are you unable to sleep because of this problem?**○No○Yes …if yes, how many nights per week: \_\_\_ | **Hobbies/ Activities** (are you able to carry out your normal duties? If No, please explain what these are and why you are unable to carry them out at present) |
| **What is the Problem?** |  |
| **bodychartWhich Body Part or Where is your problem?** **Please write below or indicate on the picture****(NB We can only address one complaint on this form)****Do you have any pins and needles or numbness?** ○No ○Yes …**if so please tell us where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |
| **How did this start?** |
| **When did this Start (what date)?** | **Since your problem has started has it:**○Got Better○Stayed the Same○ Got Worse |
| **Name D.O.B** |
| **Have you had any treatment for this condition recently or for a previous episode**○Yes : Please give details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ○No **Did it help?**○Yes ○No  |
| **Relevant medical history****Please select Yes or No for all of the following:**

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| **Condition** | **Yes** | **No** |
| Heart Problems |  |  |
| Lung problems  |  |  |
| Diabetes |  |  |
| Epilepsy |  |  |
| Major illness / Surgery |  |  |
| Family history of Rheumatoid Arthritis |  |  |
| Pins and needles / numbness |  |  |
| Fractures |  |  |
| Osteoporosis |  |  |
| Cancer (past or current) |  |  |
| Bladder or bowel problems |  |  |
| Nausea / vomiting |  |  |
| Headaches |  |  |
| Double vision |  |  |
| Unexplained weight change |  |  |
| Fainting / blackouts/ drop attacks |  |  |
| Problems with speech |  |  |
| Problems with swallowing |  |  |

**If you have answered yes to any of the above or have a condition not listed?Please give details:** | **Current medication**

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| **Medication**  | **Yes** | **No** |
| Have you ever taken steroids? |  |  |
| Have you ever taken anticoagulants (blood thinners e.g. aspirin / warfarin) |  |  |

**Please list your current medication:****Do you have any allergies:**○No ○Yes…if yes please give details:  |
| Any Investigations for this current problem? | No | Yes | If Yes please give details (e.g result / date) |
| X-ray |  |  |  |
| MRI /CT scan |  |  |  |
| Ultrasound scan |  |  |  |
| Blood tests |  |  |  |
| Other tests |  |  |  |
| **Name : DOB:** **Please name up to five of your daily activities with which you have difficulty due to your condition and score them in respect to how well or otherwise you can carry them out. 10 able to do without any problem 0 unable to do them at all. e.g. going up stairs 6/10 (moderate difficulty).**

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| **Daily Activity****EgGoing Up Stairs** | **Score**

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| **Unable****To** **Do** | **Without** **any** **Problem** |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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| **4:** |

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| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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| **5:** |

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| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
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| Please send this completed form to:Email:SC-TR.Coastal-MSK-Physios@nhs.net**Postal Return Address:**Physiotherapy DepartmentBognor Regis War Memorial HospitalShripney RoadBognor RegisPO22 9PPFax 01243 623547Unless you are a patient from *Witterings Medical Centre* or *Pulborough Medical Group* then please send to the appropriate address indicated to the rightWhen using this email address, Sussex Community NHS Trust cannot guarantee the security of this email, or be responsible for the security of any emails once sent or those in the sender's own email inbox. Once received, any personal details contained in this email will remain confidential in accordance with Sussex Community NHS Trust policies and procedures and relevant government legislation. | **Return address for Pulborough Medical Centre Patients**Physiotherapy department Pulborough Medical GroupSpiro ClosePulboroughWest SussexRH20 1FG**Return Address for Witterings Medical Centre Patients**Witterings Medical CentrePhysiotherapy DepartmentCakeham RoadEast WitteringsWest Sussex**PO20 8BH** |