

MSK Physiotherapy Services - Patient Self Referral Form

Please read this form carefully and answer **ALL** of the questions as clearly as you can.

Failure to complete the form adequately may result in it being returned to you.

Please be aware that this self referral option is **NOT** available for:

- minors (under 16)
- neurological or respiratory conditions requiring physiotherapy
- patients with complex or multiple conditions

Please note if your GP has referred you for Physiotherapy already, then you do not need to complete this form as well - we will contact you to book your appointment.

Name			
Address			
Date of birth			
GP Name and Address			
Contact Numbers	Home:	Mobile:	Work:
Can we leave message?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which language?	
Where did you hear about service?			

*** Please answer the following questions:**

Since your problem started do you have any numbness of the saddle area?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
Since your problem started have you noticed a recent change in bladder function or control?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
Since your problem started have you noticed a recent change in bowel function or control?	<input type="checkbox"/> Yes* <input type="checkbox"/> No
Did your problem start because of a major trauma – road accident or fall from height? If yes: Did you attend A&E / GP?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> A&E <input type="checkbox"/> GP <input type="checkbox"/> No
Since your problem started have you any weakness / pins and needles / loss of sensation / change in sensation in both of your arms or legs?	<input type="checkbox"/> Yes* <input type="checkbox"/> No * If yes, please give details:

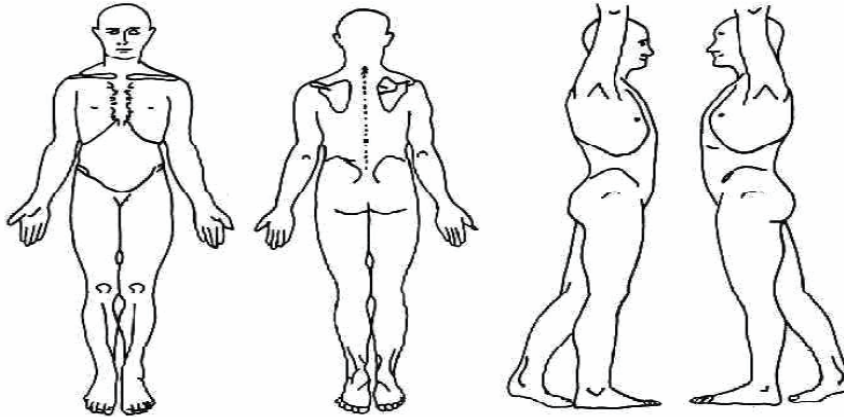
If you have answered ‘Yes*’ to any questions in the section above* and have not seen your GP then please contact your GP immediately

If you have answered ‘No’ to the questions in the section above* please turn over and complete page 2

Name		Date of birth	
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When did your problem start?	
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Please mark the symptoms (pain, pins and needles, numbness etc) on the chart below and then describe your problem for which you are seeking physiotherapy :



Description of problem / symptoms:

Is your condition making you struggle to care for yourself or any dependants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please give details:
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Do you work? Yes No Retired Self Employed

If yes, are you signed off or off work with this condition? Yes No

If yes, please give dates: From to

General Health

Do you have any other medical conditions? (Heart condition, asthma, high blood pressure, diabetes etc):

Signed	Date
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Please return the completed form to - Patient Contact Centre, Room F20 / F21, First Floor, Highfield Clinical Care Centre, Cliftonville Road, Northampton, NN1 5BU
Telephone number: 0330 555 6789